



INDIANA HEALTH COVERAGE PROGRAMS

PROVIDER REFERENCE MODULE

Hospice Services

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Version	Date	Reason for Revisions	Completed By
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Table of Contents

Section 1: Introduction	1
Medicare Conditions of Participation for Hospice Care	1
Medicaid Hospice in Conjunction with Other Funding Sources	1
Covered Services in the IHCP Hospice Per Diem	2
Hospice Core and Noncore Services	3
Comparison of IHCP Hospice Covered Services and Medicare Hospice Covered Services	4
Dialysis for End-Stage Renal Disease during Hospice Stays	4
Hospice Providers' Contractual Responsibilities as the Professional Manager of a Member's Hospice Care	5
Hospice Levels of Care	5
Routine Home Hospice Care	5
Continuous Home Hospice Care	6
Inpatient Respite Hospice Care	6
General Inpatient Hospice Care	6
Location of Routine or Continuous Home Hospice Care	7
Hospice Residence	7
Assisted Living Facility	7
Residential Care Facility Providing Residential Care Assistance Program Services	7
Intermediate Care Facility for Individuals with Intellectual Disabilities	8
Location of Inpatient Hospice Care	8
Section 2: Hospice Provider Enrollment	9
Basic Enrollment Requirements	9
Affordable Care Act Risk Category Requirements	9
Medicare Hospice Certification and State Hospice Licensure	10
Application Process for a Hospice License or Approval	10
Regulatory Process	11
Non-Medicare-Certified Hospice Providers	11
Hospice Providers Located Outside Indiana	12
Medicare-Certified Hospice Providers	12
Institutional Requirements	12
Interdisciplinary Group	13
Rights of IHCP Hospice Members	13
Section 3: Member Eligibility for Hospice Services	15
General Requirements for IHCP Hospice Benefits	15
Eligibility by Population Category	15
Managed Care Members	16
Traditional Medicaid Members	17
Dually Eligible (Medicare and Medicaid) Members	17
Members Receiving Home and Community-Based Services	18
Right Choices Program (Lock-In) Members	19
Members Residing in Group Homes	19
IHCP-Pending Individuals	19
IHCP Members without IHCP Nursing Facility Level of Care	20
Individuals in the Residential Care Assistance Program	21
Programs and Aid Categories Ineligible for the IHCP Hospice Benefit	22
Section 4: Election, Discharge, and Revocation	23
Federal Mandate under Omnibus Budget Reconciliation Act 89	23
Admission Procedures	23
Election by Member	24

Concurrent Care for Children Exception	24
Nursing Facility Residents	24
Medicaid-Only and Dually Eligible Members	24
Revocation by Member	25
Discharge by Hospice Provider	26
Discharge with Cause	27
Nursing Facility Hospice Discharge	29
Patients Admitted to a Noncontracted Nursing Facility	29
Patients Admitted to Noncontracted Hospital	29
Change in Hospice Provider	30
Short Absences for Hospice Patients	30
Medical Records Standards	32
Section 5: Hospice Authorization.....	33
Submitting Hospice Authorization Requests	33
Election, Plan of Care, and Benefit Period Process	34
Benefit Periods.....	35
Criteria for Adequate Medical Documentation	36
Documentation Requirements for Hospice Members Residing in a Nursing Facility	37
Dually Eligible Members in Nursing Facilities	38
Clarification Regarding When the IHCP Can Mirror a Hospice Agency's Benefit Periods	38
Hospice Authorization Process	40
Certification for Dually Eligible Hospice Members Residing in Nursing Facilities	44
Certification for Medicaid-Only Hospice Members.....	45
Expediting Attending Physician Signature	46
Certification Forms for Medicaid-Only Hospice Members	46
Hospice Plan of Care Documentation Requirements	46
Plan of Care for Concurrent Hospice and Curative Care Services for Children	47
Additional Hospice Authorization Forms	48
Timely Submission of Hospice Authorization Paperwork	48
Exceptions Related to Untimely Submissions	49
Administration Reconsideration and Appeals Process for Hospice Authorization	49
Hospice Coverage and Authorization for Managed Care Members.....	50
Hospice Services for HIP Members.....	50
Hospice Services for Hoosier Care Connect Members	50
Hospice Services for Hoosier Healthwise Members	51
Program of All-Inclusive Care for the Elderly.....	52
Prior Authorization for Treatment of Nonterminal Conditions	52
Request for Home Health Service Reimbursement in Addition to the Hospice Per Diem.....	53
Submission of the <i>Medicaid Hospice Discharge</i> Form and DXC Authorization Procedures	54
Hospice Authorization Guidelines for Comorbid Conditions	55
Amyotrophic Lateral Sclerosis (ALS)	55
Alzheimer's Disease and Related Disorders	56
Cardiopulmonary Disease	57
Human Immunodeficiency Virus (HIV)/Acquired Immunodeficiency Syndrome (AIDS)	59
Liver Disease	60
Renal Disease.....	61
Stroke and Coma.....	62
Adult Failure to Thrive Syndrome	62
Section 6: Billing and Reimbursement	65
Billing and Reimbursement for Concurrent Hospice and Curative Care for Children.....	65
Method of Calculation	66
Routine Home Hospice Care.....	66
Continuous Home Hospice Care.....	67

Inpatient Respite Hospice Care	68
General Inpatient Hospice Care	68
Billing Services Associated with the SIA Payment	68
Payment for Nursing Facility Residents.....	69
Room and Board	69
Decertification of a Nursing Facility and Payment of Room and Board	70
Payment for Date of Discharge	71
Patient Liability for a Hospice Member Residing in a Nursing Facility	72
IHCP Reimbursement Policy	72
Revenue Codes.....	73
Limitation of Payments for Inpatient Care.....	77
Completion of Continuation Claim Using <i>UB-04</i> Claim Form.....	78
Reimbursement for Physician Services	78
Physician Services under Revenue Codes 651 through 655	78
Physician Services under Revenue Code 657	79
Prior-Authorized Physician Services	79
Volunteer Physician Services.....	79
Emergency Services.....	80
Treatment for the Hospice Member's Nonterminal Condition	80
Outpatient Physician Services for Nonterminal Conditions.....	80
Inpatient Admission or Outpatient Hospital Services for Nonterminal Conditions	81
Admission to a Nursing Facility for Treatment of Nonterminal Conditions	81
IHCP as the Payer of Last Resort.....	85
Medicaid-Only Hospice Member Residing at Home	85
Medicaid-Only Hospice Member Residing in a Nursing Facility.....	85
Dually Eligible Hospice Member Residing at Home	86
Dually Eligible Hospice Member Residing in a Nursing Facility.....	86
Medicare or Medicaid Eligibility Changes during the Month.....	86
Medicaid-Only Hospice Member in a Nursing Facility Becomes Medicare-Eligible	86
Dually Eligible Hospice Member in a Nursing Facility Becomes Medicaid-Only	87
Payment for Briefs for Hospice Patients in Nursing Facilities.....	87
Common Hospice Explanation of Benefits Codes	88
Section 7: IHCP Recoupment.....	93
FSSA Recoupment from Nursing Facilities	93
Surveillance and Utilization Review Documentation Standards.....	93
Recognition of Hospice Review Process at 405 IAC 5-34-4.2	94
Medical Records Review	94
Hospice Plan of Care Review	96
Other Hospice Review Criteria	96
IHCP Recommendations for Hospice Provider Coordination.....	97
Recommendations for Hospice Members Residing in a Nursing Facility	97
Recommendations for Medicaid-Only Hospice Members Residing at Home	98
Section 8: Hospice Care in Nursing Facilities	101
Hospice Conditions of Participation	101
Requirements for Billing Hospice Services Provided in a Nursing Facility	102
B98 Autoclosures	103
Payment and Billing Parameters for Hospice and Nursing Facilities	103
CMS Clarification Regarding Nutritional Supplements.....	104

Section 1: Introduction

*Note: The information in this module applies to Indiana Health Coverage Programs (IHCP) hospice services provided under the **fee-for-service (FFS)** delivery system. For hospice services provided through the **managed care** delivery system – including Healthy Indiana Plan (HIP) and Hoosier Care Connect hospice services – providers must contact the member's managed care entity (MCE) or refer to the MCE provider manual. MCE contact information is included in the [IHCP Quick Reference Guide](#) available at in.gov/medicaid/providers.*

For updates to information in this module, see [IHCP Banner Pages and Bulletins](#) at in.gov/medicaid/providers.

Hospice care is a specialized form of interdisciplinary healthcare designed to alleviate the physical, emotional, social, and spiritual discomforts of an individual who is experiencing the last phase of a terminal illness or disease. Hospice care also provides for the psychological, social, spiritual, and other needs of the hospice program patient's family before and after the patient's death.

This document outlines key policies and procedures associated with the Indiana Health Coverage Programs (IHCP) hospice benefits. Indiana state statute mandated the Family and Social Services Administration (FSSA) implement a Medicaid hospice benefit effective July 1, 1997. State statute requires that the Medicaid hospice benefit mirror the Medicare hospice program with regard to hospice covered services and reimbursement methodology.

Medicare Conditions of Participation for Hospice Care

Indiana state statute requires a hospice provider to be Medicare-certified as a hospice before enrolling in the IHCP as a Medicaid hospice provider. The IHCP further requires a hospice to be licensed by the Indiana State Department of Health (ISDH) as a requisite to enrollment as a Medicaid hospice provider. As such, the IHCP expects hospice providers to comply with the Medicare hospice conditions of participation, under *Code of Federal Regulations 42 CFR 418*. Providers may view the federal hospice regulations on the [Hospice Agency Licensing and Certification Program](#) page at in.gov/isdh.

Medicaid Hospice in Conjunction with Other Funding Sources

Hospice providers should remember that the Medicare and Medicaid hospice programs are primarily for the treatment of terminal illness and related conditions. Home and Community-Based Services (HCBS) waiver programs and Community and Home Options to Institutional Care for the Elderly and Disabled (CHOICE) may supplement Medicare or Medicaid hospice. From a funding-stream perspective, the IHCP has always noted that there is a hierarchy of funding streams as follows:

1. Private pay/Medicare (Medicare hospice)
2. Medicaid (Medicaid hospice)
3. HCBS waiver programs
4. CHOICE

Federal Medicare regulations require hospices to list on the plan of care the frequency and scope of all hospice-covered services needed to treat the terminal condition. In an effort to ensure better coordination among the personal care services, the IHCP requires hospice providers to submit the following additional documentation:

- On the *Indiana Health Coverage Programs Prior Authorization Request Form* or authorization request submitted via the IHCP Provider Healthcare Portal (Portal), the hospice must list other caregiving services received by the member, including, but not limited to, services provided by HCBS waiver programs or CHOICE.
- The hospice plan of care must list the frequency and scope of the visits planned by each discipline to treat the member's terminal illness and related conditions.
- The hospice plan of care must also list the frequency and scope of overlapping services provided by the HCBS waiver program or CHOICE for the member's nonterminal conditions.

The IHCP requests this additional information to ensure coordination among the different hospice provider case managers. The IHCP prior authorization contractor, DXC Technology, can approve the medical necessity only with regard to the hospice care. The HCBS waiver case managers and CHOICE case managers must adjust their respective care plans. The IHCP or the FSSA has the discretion to review care plans from various programs to ensure that there is no duplication of service across program lines when serving a member.

Covered Services in the IHCP Hospice Per Diem

In accordance with *Indiana Administrative Code 405 IAC 5-34-8*, services covered in the IHCP hospice per diem reimbursement rates include the following:

- Nursing care provided by or under the supervision of a registered nurse
- Medical social services provided by a social worker who has a bachelor's degree or higher and who is working under the supervision of a physician
- Physician services provided by the medical director or physician member of the interdisciplinary team, characterized as follows:
 - General supervisory services
 - Participation in the establishment of the plan of care
 - Supervision of the plan of care
 - Periodic review
 - Establishment of governing policies (for example, services covered by hospice per diem revenue codes 650, 651, 652, 655, and 658)
- Counseling services provided to the member and the member's family or other person caring for the member
- Short-term inpatient care provided in a hospice inpatient unit, participating hospital, or nursing facility subject to the limitations in *405 IAC 1-16-3*
- Medical appliances and supplies, including palliative drugs related to the palliation or management of the member's terminal illness
- Home health services furnished by qualified aides
 - The Medicare home health condition of participation at *42 CFR 484.36* defines the skills, attitude, and training requirements of home health aides
 - The Medicare hospice condition of participation at *42 CFR 418.76* defines the training, supervision, and duties of the hospice aide.

- Homemaker services that assist in providing a safe and healthy environment
 - The hospice must ensure that the instructions for homemaker services are noted in the hospice plan of care, and the proper supervision, reporting, and documentation requirements are met as required by 42 CFR 418.76.
- Physical therapy, occupational therapy, and speech-language pathology services provided for symptom control
- Inpatient respite care, subject to the limitations in 405 IAC 1-16-2
- Room and board for dually eligible (Medicare and Medicaid) hospice members residing in nursing facilities as covered by hospice per diem revenue code 659, as described in 405 IAC 1-16-4
- Room and board for Medicaid-only hospice members residing in nursing facilities as covered by hospice per diem revenue codes 650 or 658, as described in 405 IAC 1-16-4
- Any other item or service specified in the member's hospice plan of care, if the item or service is a covered service under the Medicare program

For an individual to receive Medicaid-covered hospice services, a physician must certify in writing that the individual is terminally ill and expected to die from that illness within 6 months, if the terminal illness runs its normal course (see [Section 3: Member Eligibility for Hospice Services](#)). Services provided in hospice care must be reasonable and medically necessary for the palliation or management of the terminal illness.

*Note: IHCP-enrolled children 20 years of age and under who elect the IHCP hospice benefit may also receive **curative care** services for the terminal condition, concurrent with hospice care. Curative services must be medically necessary and included as part of the hospice plan of care, as described in the [Plan of Care for Concurrent Hospice and Curative Care Services for Children](#) section. When the IHCP member elects concurrent hospice and curative care benefits, the palliation and management of the terminal condition comes under the supervision of the IHCP hospice provider. Curative care services are covered separately from hospice services.*

Hospice Core and Noncore Services

The IHCP hospice benefits mirror the Medicare hospice program in defining *hospice core services* and *hospice noncore services*.

- **Hospice core services** are covered services in the Medicare and IHCP hospice per diem that must be provided directly to members by hospice employees. Hospice core services include the following:
 - Hospice nursing care
 - Hospice medical social services
 - Hospice physician services (general supervisory services, participation in establishment of the plan of care, supervision of the plan of care, periodic review, and establishment of governing policies)
 - Hospice counseling services (including bereavement, dietary, spiritual, and other counseling)
- **Hospice noncore services** are any services, in the Medicare or IHCP hospice per diem, not identified as hospice core services. Hospice providers may contract other healthcare professionals to provide hospice noncore services. However, the hospice must still retain oversight as the manager of the member's hospice care.

Nonhospice physician services (that is, physician services other than those specified in 405 IAC 5-34-8(3)) represent another distinct service category. However, these services are reimbursed on a fee-for-service basis and are not affected by the location-of-care category. For additional information, see [Section 6: Billing and Reimbursement](#).

Comparison of IHCP Hospice Covered Services and Medicare Hospice Covered Services

Table 1 demonstrates how the IHCP hospice per diem mirrors the services covered under the Medicare hospice program, as described in the Medicare hospice conditions of participation. Hospice providers may refer to 42 CFR 418 for a more thorough review of the Medicare hospice conditions of participation.

Note: Hospice providers are reminded that any case-specific issues about the development of a plan of care for a Medicare beneficiary must be directed to the agency's Part A Medicare Administrative Contractors (MACs).

Table 1 – IHCP and Medicare Hospice Services, by State and Federal Regulation

Hospice Service	State Regulations	Federal Regulations
Nursing services	405 IAC 5-34-8(1)	42 CFR 418.64(b) and 418.66
Medical social services	405 IAC 5-34-8(2)	42 CFR 418.64(c)
Physician services	405 IAC 5-34-8(3)	42 CFR 418.64(a)
Counseling services	405 IAC 5-34-8(4)	42 CFR 418.64(d)
Short-term inpatient care	405 IAC 5-34-8(5)	42 CFR 418.108(a)
Medical appliances and supplies	405 IAC 5-34-8(6)	42 CFR 418.106
Home health services provided by a hospice aide or home health aide	405 IAC 5-34-8(7)	42 CFR 418.76 and 484.36
Homemaker services	405 IAC 5-34-8(8)	42 CFR 418.76
Physical therapy, occupational therapy, and speech-language pathology provided for purposes of symptom control	405 IAC 5-34-8(9)	42 CFR 418.72
Inpatient hospice respite care	405 IAC 5-34-8(10)	42 CFR 418.108(b)
Room and board for hospice members residing in a nursing facility	405 IAC 5-34-8(11)	The Medicare program does not provide payment for room and board.
Any other item or service specified in the hospice plan of care, if the item or service is a Medicare-covered service	405 IAC 5-34-8(12)	

Dialysis for End-Stage Renal Disease during Hospice Stays

If a patient who is on dialysis for end-stage renal disease (ESRD) is admitted to hospice with a non-ESRD primary diagnosis, such as chronic obstructive pulmonary disease (COPD) or Alzheimer's, the patient may continue to receive dialysis treatments during the hospice stay.

[Chapter 9](#), Section 40.1, of the *Medicare Benefit Policy Manual* (CMS Pub. 100-02), states that any item or service that is included in the plan of care, and for which payment may be otherwise made by Medicare, is a covered hospice service under the Medicare hospice benefit. So if the hospice is responsible for providing all services indicated in the plan of care as reasonable and necessary for the palliation and management of the terminal illness, then dialysis, in this case, is a covered hospice service. However, there is no additional payment made. Most hospices have across-the-board admission policies indicating that they do not accept patients who still want to receive dialysis, which hospice providers can do as long as they do not discriminate against Medicare patients.

Hospice Providers' Contractual Responsibilities as the Professional Manager of a Member's Hospice Care

Federal regulations at *42 CFR 418.112(b)* specify that the hospice provider is the professional manager of the hospice member's hospice care. As such, the hospice provider's responsibilities include coordinating the plan of care and ensuring that the plan of care is consistent with the hospice philosophy of care.

If the hospice patient requires care from another healthcare professional, outpatient clinic, or inpatient clinic for treatment of the terminal illness or related conditions, it is the responsibility of the hospice to obtain a contract with the healthcare professional or other healthcare provider for the arranged services. The contract must contain the minimum criteria stated in *42 CFR 418.100(e)* and specify that it is the responsibility of the hospice to pay the contracted provider for the arranged services. The hospice provider must also ensure that the contracted provider understands that it is inappropriate for the contracted provider to bill Medicare or the IHCP directly for the contracted services, because the hospice provider reimburses the contracted provider directly.

The hospice provider must ensure that noncore services are provided directly by the hospice or under arrangements made by the hospice as specified in *42 CFR 418.100*.

Hospice Levels of Care

Hospice providers are required to comply with federal hospice regulations at *42 CFR 418* and the *Balanced Budget Act of 1997*, which requires hospice providers to list on the hospice plan of care all hospice covered services, in frequency and scope, necessary to treat the terminal illness and related conditions. See [Hospice Plan of Care Documentation Requirements](#), in *Section 5*, for more information about plan-of-care requirements.

Furthermore, hospice providers must provide care based on the medical acuity of the member at one of four distinct hospice levels of care (LOCs):

- Routine home hospice care
- Continuous home hospice care
- Inpatient respite hospice care
- General inpatient hospice care

The LOC delivered is determined by the hospice provider within the context of overall use and reimbursement limitations described in [Section 6: Billing and Reimbursement](#).

Inpatient hospice care must be provided in an inpatient unit or contracted inpatient facility that meets the parameters at *42 CFR 418.110 et seq.*

For purposes of reimbursement, a distinction is made between a home in a nursing facility (NF) and a home in any other type of setting. However, each of these locations is considered the **home** of a hospice member because it is his or her normal place of residence. (See [Location of Routine or Continuous Home Hospice Care](#).)

Routine Home Hospice Care

A routine home hospice care day is a day on which an individual who has elected to receive hospice care is at home and is not receiving continuous home hospice care.

Continuous Home Hospice Care

Hospice providers should follow the parameters for continuous home hospice care outlined in [Chapter 9, Section 40.2.1](#), of the *Medicare Benefit Policy Manual*.

Continuous home hospice care can be provided during a period of crisis to maintain the individual at home. A *period of crisis* is defined as a time in which the patient requires *predominantly nursing care* to achieve palliation or management of acute *medical* symptoms. For example, if a caregiver has been providing a skilled LOC and becomes unable or unwilling to continue providing the care, this development may precipitate a period of crisis, because the skills of a nurse may be required to replace the services that had been provided by the caregiver.

Under the continuous home hospice care LOC, the hospice must provide a minimum of **8 hours** of primarily nursing care during a 24-hour day:

- The 24-hour day begins and ends at midnight.
- The care need not be *continuous*.
- Nursing care provided by a registered nurse (RN) or licensed practical nurse (LPN) must be provided for *at least half* of the period of care:
 - The skilled care provided by the nurse may be supplemented by a home health aide.
 - If the majority of the care can be accomplished by a home health aide, the care rendered would be covered as a routine home hospice care day.
- When fewer than 8 hours of care are provided, the care is reimbursed at the routine home care rate.

Documentation should clearly indicate the nature of the medical crisis and the need for skilled intervention, and illustrate, hourly and daily, the level of staffing and the services that were provided.

Inpatient Respite Hospice Care

Inpatient respite hospice care is short-term inpatient care provided to the member, only when necessary, to relieve the primary caregivers. Inpatient respite hospice care may be provided only on an occasional basis. Inpatient respite hospice care may be provided in a nursing facility that meets the parameters in *42 CFR 418.108(b)*.

The Centers for Medicare & Medicaid Services (CMS) hospice final rules state the care needs of a respite patient are equivalent to those of the patient in his or her home and, therefore, may not necessitate registered nursing care on a 24-hour basis. Rather, staffing for a facility solely providing the respite level of care to hospice patients should be based on each patient's care needs. The requirements for respite care can be found in *42 CFR 418.108(b)*.

General Inpatient Hospice Care

Federal regulations at *42 CFR 418.110 et seq.* specify the condition of participation for general inpatient hospice care and should be reviewed in their entirety. All condition-of-participation requirements must be met, whether a hospice provides general inpatient care in its own inpatient unit or by arrangement with another entity. Unless the nursing facility is a skilled nursing facility (SNF) in a hospital setting, most nursing facilities do not meet the skilled nursing requirement for this level of care. Specifically, the nursing facility must provide 24-hour RN coverage, **and** the RN at the nursing facility must be capable of providing the pain management required for this LOC. The presence of an RN on staff at the nursing facility for 24 hours per day is not sufficient to meet the requirements at *42 CFR 418.110 et seq.*

Location of Routine or Continuous Home Hospice Care

Routine and continuous home hospice care may be provided in a member's place of residence, which can be any residential setting other than an inpatient hospital setting.

The following sections address case-specific reminders regarding the provision of routine or continuous hospice care in hospice residences, assisted living facilities, residential care facilities, and intermediate care facilities for individuals with intellectual disabilities (ICFs/IID). For patients receiving routine or continuous home hospice services while residing in a nursing facility, see [Section 6: Billing and Reimbursement](#) for special requirements regarding reimbursement and coordination of care.

Hospice Residence

Hospice providers may have hospice residences where members receive routine or continuous hospice care and pay the hospice room and board, or they may have hospice inpatient units where members may receive routine, continuous, or general inpatient hospice care. It is important that the hospice medical chart reflect and support the appropriate hospice level of care rendered in either location.

Assisted Living Facility

In the state of Indiana, assisted living facilities are not required to be licensed. Residential care facilities are licensed under *Indiana Code IC 16-28* and may provide minimal care to residents. ISDH regulations for residential rules are found on the [Residential Care Facility Licensing Program](#) page at in.gov/isdh.

Hospice providers should provide all hospice services as though the patients are in their own home. If the hospice is working with a licensed residential care facility, see the criteria found in *42 CFR 418.112(c)*. The qualifications of staff available at the licensed residential care facility should be verified if staff members are to administer medications.

Case-specific survey questions regarding hospice care should be directed to the ISDH Acute Care Unit at (317) 233-7474. Case-specific issues regarding assisted living and residential care facilities should be directed to the ISDH Long Term Care Unit at (317) 233-7442.

IHCP hospice authorization is not required for dually eligible members residing in assisted living facilities or receiving assisted living services under the Aged and Disabled waiver. Reimbursement requires the hospice to bill Medicare or Medicaid for the hospice per diem. The assisted living facility is reimbursed by the member for room and board.

Residential Care Facility Providing Residential Care Assistance Program Services

Most residential care facilities are licensed and may provide minimal care to residents. If the hospice is working with a licensed residential care facility, see the criteria found at *42 CFR 418.112(c)*. County-operated Residential Care Assistance Program (RCAP) providers are not licensed as residential care facilities.

The FSSA Division of Aging (DA) administers the RCAP. The RCAP rate pays for room and board, laundry, and minimal administrative direction. The RCAP rate does not include a skilled nurse component. For more information about the RCAP or a current listing of facilities participating in the RCAP, contact the program coordinator within the FSSA DA at (317) 234-2944 or 1-888-673-0002.

Medicaid-eligible individuals residing in a residential care facility and enrolled in the RCAP can elect the IHCP hospice benefit. However, the IHCP does **not** pay additional room and board for these individuals.

It is important to know that individuals enrolled in the RCAP who reside in county homes are not eligible for IHCP hospice benefits, as the residents' aid category of Aid to Residents in County Homes (ARCH) makes them ineligible.

Intermediate Care Facility for Individuals with Intellectual Disabilities

When providing hospice services to a resident of an ICF/IID, the hospice must have a coordinated plan of care with the ICF/IID. The coordinated plan of care must outline the responsibilities of each entity. The hospice needs to ensure that it provides core services for the ICF/IID resident. The qualifications of staff available at the ICF/IID should be verified if the staff is to administer medications. Federal regulations at 42 CFR 418.112 should be reviewed in their entirety.

Case-specific survey questions regarding hospice care should be directed to the ISDH Acute Care Unit at (317) 233-7474. Case-specific issues regarding assisted living and ICF/IIDs should be directed to the ISDH Long Term Care Unit at (317) 233-7442.

For reimbursement, the hospice should bill Medicare or Medicaid for the hospice per diem, and the ICF/IID should continue to bill Medicaid for the ICF/IID per diem.

Location of Inpatient Hospice Care

Short-term inpatient hospice care is offered under two levels of care: *inpatient respite hospice care* and *general inpatient hospice care*. Inpatient hospice care may be offered in any of the following settings:

- Hospice inpatient facility or unit
- Hospital
- Skilled nursing facility
- Nursing facility – Hospice respite only

Table 2 specifies the requirements a hospice must follow when inpatient hospice care is provided directly or under arrangement.

Table 2 – Hospice Inpatient Care Requirements

Inpatient Care Provided Directly	Inpatient Care Provided Under Arrangement
Hospice owns the facility that must meet the requirements outlined in 42 CFR 418.110 <i>et seq.</i>	Medicare-certified hospital that must meet the requirements outlined in 42 CFR 418.110 <i>et seq.</i>
Hospice leases space in a facility that must meet the requirements outlined in 42 CFR 418.110 <i>et seq.</i>	Medicare-certified SNF that must meet the requirements outlined in 42 CFR 418.110 <i>et seq.</i>
Space in a Medicare hospital or SNF/NF that must meet the requirements outlined in 42 CFR 418.110 <i>et seq.</i>	Medicare-certified hospice that must meet the requirements outlined in 42 CFR 418.110 <i>et seq.</i>
Because hospice provides inpatient care directly, a written agreement is not required under 42 CFR 418.100(e).	Hospice must have a written agreement with the contracted facility that meets the requirements of 42 CFR 418.100(e).

Section 2: Hospice Provider Enrollment

This section provides information and requirements about becoming a hospice provider in the Indiana Health Coverage Programs (IHCP).

Basic Enrollment Requirements

Hospice provider participation in the IHCP requires submission of the following documentation:

- The [IHCP Hospital and Facility Provider Enrollment and Profile Maintenance Packet](#) or equivalent application through the Provider Healthcare Portal (Portal)
 - This packet or online application must be completed even when a provider currently participates as an IHCP provider of another type of service.
 - The hospice provider must have obtained a National Provider Identifier (NPI) before completing the application.
 - The packet, which includes the *IHCP Provider Agreement*, is available on the [Complete an IHCP Enrollment Application](#) page at in.gov/medicaid/providers. Online application is available through the [IHCP Provider Healthcare Portal](#), accessible from the home page at in.gov/medicaid/providers.
- A copy of the provider's *Medicare Hospice Certification Letter* from the Centers for Medicare & Medicaid Services (CMS) for each hospice office location
- A copy of a Certification and Transmittal (C&T) sent to DXC Technology from the Indiana State Department of Health (ISDH) for each hospice office location

See the [Provider Enrollment](#) module for more information about enrolling as a provider in the IHCP.

Affordable Care Act Risk Category Requirements

The *Affordable Care Act* assigns all providers to a risk category, describing the degree of probability of fraud or abuse. Hospice providers are assigned to the Moderate risk category. As a result, the following activities occur for hospice providers that are newly enrolling:

- Unscheduled, unannounced site visits (these visits can occur before and after enrollment)
- License verification
- Proof of Medicare enrollment, if Medicare-enrolled
- Denial of enrollment to providers sanctioned by Medicare or another state's Medicaid program
- Validation of disclosed individuals such as owners and managerial persons responsible for day-to-day operations, including members of a board of directors)
- Application fee
 - Providers already enrolled in Medicare pay the fee to Medicare, not to the IHCP.
 - Medicaid-only providers pay the fee to the IHCP.
- Revalidation
 - Hospice providers are required to revalidate (reenroll) in the IHCP every 5 years.

These screening activities are also applicable to existing IHCP-enrolled providers during the revalidation process.

Because Medicare also performs the screening activities required by the *Affordable Care Act*, the IHCP accepts the results of screening activities performed by Medicare.

Medicare Hospice Certification and State Hospice Licensure

Medicare hospice certification confirms the provider meets all Title XVIII standards for Medicare hospice participation. Per the requirements outlined in *Indiana Administrative Code 405 IAC 5-34-3(b)* and *(c)*, a hospice provider must be certified as a hospice provider in the Medicare program to be enrolled as an IHCP hospice provider. A copy of the provider's *Medicare Hospice Certification Letter* from the CMS must be submitted with the *IHCP Enrollment and Profile Maintenance Packet*. A hospice provider operating more than one location must provide a copy of the Medicare certification letter from the CMS demonstrating that the regional office has approved each additional office location to be Medicare-certified as a satellite office of the home office location or as a separate hospice with a unique Medicare provider number.

The provider must comply with all state and federal requirements for Medicaid and Medicare providers. Furthermore, the hospice and all hospice employees with skill sets requiring an Indiana state license must be licensed in accordance with federal, state, and local laws and regulations as required under federal regulations at *Code of Federal Regulations 42 CFR 418.62* and Indiana state hospice licensure or approval at *Indiana Code IC 16-25-3*.

The following sections provide further information about Indiana state licensure of hospices, the application process for a hospice license or approval, and the regulatory process.

Pursuant to *IC 16-25-3-1*, State-licensed hospitals, health facilities, and home health agencies that operate a hospice program in Indiana must be approved to do so by the State, but are not required to have a hospice license. All other persons who operate a hospice program in the state of Indiana must be licensed to do so by the ISDH. Such license issued or approval granted authorizes the owner or operator of a hospice program to provide hospice services.

Application Process for a Hospice License or Approval

A provider must submit an application for a hospice license, or for approval to operate a hospice program, on a form prescribed by the ISDH. Any documentation requested on the form must also be submitted. License or approval to operate a hospice program must be renewed annually. Applicants must include the license fee with the initial application, and annually thereafter with applications for renewal.

Each application must include the following:

- A single disclosure document, which includes the components outlined in *IC 16-25-7*, prepared by the hospice program and updated, as necessary, and used for presentation to each potential patient of the hospice program
- A copy of the administrator's or director's completed criminal history report, pursuant to *IC 16-25-6*
- A copy of the medical director's license and resume
- A copy of the patient or family care coordinator's license and resume
- A copy of the *Certificate of Incorporation*, signed by the Indiana secretary of state, for all Indiana corporations; or, if the applicant is an out-of-state corporation, a copy of the *Certificate of Authority* signed by the Indiana secretary of state
- A list of each home health aide employed, contracted, or used (including as volunteers) by the applicant at the time of the application, including date of hire, pursuant to *IC 16-25-6*
- Copies of completed criminal history reports for each home health aide listed by the applicant
- A list of each volunteer used by the provider at the time of the application, including date of hire, pursuant to *IC 16-25-6*

- Copies of completed criminal history reports for each volunteer listed by the applicant, pursuant to *IC 16-25-6*
- Documentation by the provider of the inquiry to the State Nurse Aide Registry about each home health aide listed on the application

Regulatory Process

The hospice program must meet the minimum standards for certification under the Medicare program and comply with the regulations for hospices under *42 CFR 418.1 et seq.* or be certified by the Medicare program to obtain a license of approval to operate a hospice program pursuant to *IC 16-25-3*. Hospice providers must comply with all state and federal requirements for Medicaid and Medicare providers, in addition to the requirements in this section. The hospice and all hospice care employees must be licensed and comply with all applicable federal, state, and local laws and regulations as required under federal regulations stated in *42 CFR 418.62*.

It is important to note that the federal government expects hospice corporations or agencies to contact the appropriate state survey agency so each new office location can be Medicare-certified, either as a satellite office of the parent hospice location or as a stand-alone hospice, before billing Medicare for services rendered to Medicare hospice patients. Out-of-state hospice providers seeking to render services to Indiana Medicare and Medicaid members must be licensed or approved by the ISDH. The ISDH cannot accept any other state license. See the [Hospice Providers Located in Designated Out-of-State Areas](#) section for the steps to obtain an Indiana State hospice license or approval.

Hospice providers are reminded to direct questions about State hospice licensure or Medicare certification application to the ISDH.

Non-Medicare-Certified Hospice Providers

Indiana providers that do **not** meet Title XVIII standards for Medicare hospice participation are required to obtain certification before attempting to enroll as an IHCP hospice provider. Providers should contact the Acute Care Services Division of the ISDH to obtain certification.

Inquiries about Medicare hospice certification and Indiana state hospice licensure should be directed to the following address or telephone number:

**Acute Care Services
Indiana State Department of Health
2 North Meridian Street, Section 4A
Indianapolis, IN 46204
Telephone: (317) 233-7474**

Out-of-state providers, as described in the following section, should first contact the relevant Medicare hospice certification authority in their states about Medicare certification, and the Acute Care Services Unit of the ISDH about Indiana hospice licensure requirements.

Indiana law does not permit the ISDH to enter into reciprocal agreements with other state agencies concerning state hospice licensure. Therefore, the ISDH cannot accept any other state hospice license as satisfying Indiana licensing requirements. The following section outlines the impact this law has on providers located in designated out-of-state areas described in *405 IAC 5-5-2(a)*.

Hospice Providers Located Outside Indiana

Hospice providers must be enrolled in the IHCP as a hospice provider, as outlined in *405 IAC 5-34-2* and *405 IAC 5-34-3*. Hospice providers must obtain an Indiana state hospice license, as the ISDH does not recognize reciprocity of hospice licensure from other state survey agencies.

Indiana law does not permit the ISDH to enter reciprocal agreements with other state agencies concerning Indiana hospice licensure. Therefore, the ISDH cannot accept any other state hospice license (including Ohio, Illinois, Michigan, or Kentucky) as satisfying Indiana licensing requirements. The ISDH does not have the legal authority to cross state lines to survey out-of-state hospice providers.

Out-of-state hospice providers need to take the following steps to obtain an Indiana State hospice license and approval:

- Open a fully operational, fully staffed hospice office location in Indiana that complies with all the Medicare hospice conditions of participation in *42 CFR 418*.
- Contact the ISDH Acute Care Division for information about the application process to obtain a State hospice license or approval.
- Contact the ISDH Acute Care Division to obtain an application for Medicare certification for the Indiana hospice office license. If the hospice decides to have the state survey agency of the parent office perform the Medicare certification survey, the hospice should provide the ISDH Acute Care Division with a copy of that *Medicare Hospice Certification Letter*.

Medicare-Certified Hospice Providers

Providers that already meet standards for Medicare hospice participation and are licensed to provide hospice care in Indiana can enroll directly as IHCP hospice providers by completing an *IHCP Hospital and Facility Provider Enrollment and Profile Maintenance Packet* or by submitting an application through the Portal. In addition, the ISDH must also send a copy of the provider's C&T directly to DXC. Verification of a current Indiana state hospice license or approval is also required with the IHCP application.

Requirements of the *Affordable Care Act* (see the [Affordable Care Act Risk Category Requirements](#) section) must be satisfactorily completed before an enrollment is approved.

A hospice provider entitled to reimbursement by the IHCP is defined as a public or private organization, or subdivision of either, primarily engaged in providing care to terminally ill individuals and their families. The organization is certified under Medicare hospice conditions of participation after completing State hospice licensure requirements, and has a valid *IHCP Provider Agreement* indicating intent to provide hospice services.

Institutional Requirements

As with enrollment in other IHCP services, hospice enrollment is associated with established policies for service delivery, record maintenance, disclosure of information, reimbursement, Surveillance and Utilization Review (SUR), licensing, termination of participation, and appeal rights. For more about these established policies, see the applicable provider reference modules on the [IHCP Provider Reference Modules](#) page at in.gov/medicaid/providers.

In addition to these established policies, IHCP hospice providers must meet the following requirements for the hospice interdisciplinary group and delivery of hospice services to the hospice member.

Interdisciplinary Group

The hospice provider must designate an interdisciplinary group comprising individuals who are employees of the hospice and who provide or supervise care and services offered by the hospice provider. At a minimum, this group must include the following:

- A medical director, who must be a doctor of medicine or osteopathy
- A registered nurse
- A social worker
- A pastoral or other counselor

This interdisciplinary group has the following responsibilities:

- Participate in the establishment of the plan of care.
- Provide or supervise hospice care and services.
- Review and update the plan of care.
- Establish policies governing the day-to-day provision of care and services.

State hospice licensure requires hospice providers to comply with Medicare hospice conditions of participation. The hospice provider, through its interdisciplinary team, must ensure that all patients are offered the same services, including medically necessary services, regardless of residence (nursing facility versus private home or other residential setting) or payer source (private insurance, Medicare, or Medicaid).

Rights of IHCP Hospice Members

The hospice provider must not discontinue or diminish care provided to an IHCP member because of the member's inability to pay, nor can the hospice provider fail to respect the individual's rights to an informed consent.

Section 3: Member Eligibility for Hospice Services

This section provides Indiana Health Coverage Programs (IHCP)-enrolled hospice providers with specific information about member eligibility. This section also provides information about the hospice provider's responsibility for hospice authorization and the coordination responsibilities for individuals enrolled in specific programs at the time the IHCP member elects hospice care. For detailed information about hospice authorization, see [Section 4: Election, Discharge, and Revocation](#) and [Section 5: Hospice Authorization](#) in this module.

The information in this section is not meant to serve as a replacement for compliance with the *IHCP Provider Agreement*. The hospice provider must review the following information regarding member eligibility:

- The [Member Eligibility and Benefit Coverage](#) module
- Any provider bulletins or banner pages the IHCP releases about IHCP member eligibility, the Interactive Voice Response (IVR) system, and the Provider Healthcare Portal (Portal)

The [IHCP Provider Reference Modules](#) and [provider bulletins and banner pages](#) are available at in.gov/medicaid/providers.

General Requirements for IHCP Hospice Benefits

Hospice members can be Medicaid-only eligible or dually eligible for both Medicare and Medicaid. However, all hospice members must be certified as terminally ill.

*Note: A member is considered **terminally ill** if, given that the illness runs its normal course, the medical prognosis suggests a life expectancy of 6 months or less.*

Any IHCP member receiving full Medicaid benefits who is terminally ill and meets medical necessity criteria may receive services from an IHCP hospice provider. Different IHCP programs may have different prior authorization and plan-of-care requirements for coverage.

Eligibility by Population Category

Hospice providers are reminded that some IHCP members have limitations or restrictions on coverage. Although terminally ill individuals eligible for IHCP benefits may be eligible for IHCP hospice care, different population categories have different relationships to the hospice benefit.

The following sections provide IHCP hospice eligibility and limitation information based on aid category and benefit package. See the [Programs and Aid Categories Ineligible for the IHCP Hospice Benefit](#) section for programs and aid categories not eligible for the IHCP hospice benefit.

The *IHCP Provider Agreement* specifies that it is the IHCP-enrolled hospice provider's responsibility to verify IHCP eligibility regularly by using one of the Eligibility Verification System (EVS) options described in the [Interactive Voice Response System](#), [Electronic Data Interchange](#), and [Provider Healthcare Portal](#) modules. The *IHCP Provider Agreement* is part of the [IHCP Hospital and Facility Provider Enrollment and Profile Maintenance Packet](#) available at in.gov/medicaid/providers, as well as the application available online via the Portal.

Managed Care Members

Members who receive medical services under the managed care delivery system – Healthy Indiana Plan (HIP), Hoosier Care Connect, Hoosier Healthwise, or Program of All-Inclusive Care for the Elderly (PACE) – are eligible for hospice benefits.

The hospice provider must follow case-specific eligibility verification when the client is a member of an IHCP managed care program, including HIP, Hoosier Care Connect, and Hoosier Healthwise. See [Hospice Coverage and Authorization for Managed Care Members](#), under *Section 5: Hospice Authorization*.

Healthy Indiana Plan

HIP coverage includes in-home and institutional hospice services. HIP members receiving hospice services remain enrolled in managed care with their managed care entity (MCE).

Specific hospice benefits for HIP members vary by benefit plan:

- *HIP Plus* and *HIP Basic* hospice benefits mirror the covered services and reimbursement methodology of the Medicare hospice program. Covered services include a semiprivate room; a private room is provided when medically necessary. Concurrent curative care is covered for HIP members who are 19 and 20 years of age. Room-and-board services are not covered when temporary leave days are permitted.
- *HIP State Plan Plus* and *HIP State Plan Basic* hospice benefits mirror those of Traditional Medicaid. Covered benefits include the hospice core services covered under the Medicaid hospice per diem. Services included in the per diem that are not considered core services are noncovered for *HIP State Plan* members.

Hoosier Care Connect

All covered hospice benefits for members enrolled in Hoosier Care Connect are the responsibility of the enrolling health plan. Hoosier Care Connect members remain enrolled with their MCE for the duration of the hospice period.

A member enrolled in Hoosier Care Connect is eligible to receive all hospice levels of care available under the hospice benefit: routine home care, continuous home care, inpatient respite care, and general inpatient care.

The hospice provider is responsible for coordinating all hospice services with the member's MCE, including obtaining PA and ensuring the member has an institutional hospice level of care, as appropriate.

Hoosier Healthwise

Hoosier Healthwise members electing IHCP hospice benefits are required to disenroll from the managed care program and enroll with Traditional Medicaid. Disenrollment is necessary for hospice authorization to be completed. Members become eligible for hospice services the business day following disenrollment from the MCE.

Program of All-Inclusive Care for the Elderly

If a PACE member elects IHCP hospice benefits, he or she is disenrolled from PACE and would need to enroll in Traditional Medicaid, unless the member's PACE facility elects to provide hospice services to that PACE member (in which case, he or she will remain enrolled in the PACE managed care program). Members choosing to disenroll from PACE may risk losing Medicaid eligibility due to the enhanced income allowances under PACE and other home and community-based services. PACE members are encouraged to consult with their PACE provider when considering disenrollment or end-of-life care.

Traditional Medicaid Members

The IHCP covers hospice services for Traditional Medicaid members (enrolled in the Full Medicaid or Package A – Standard Plan benefit plan, on a fee-for-service basis).

Prior authorization is required for in-home and institutional hospice services, as described in this module.

Dually Eligible (Medicare and Medicaid) Members

Individuals eligible for Medicare Part A and Medicaid (dually eligible members) receive hospice services through the Medicare program. The IHCP does reimburse for certain services **not** covered under the Medicare hospice benefit, such as copays for respite care and deductibles for medications. Accordingly, the IHCP requires the following:

- Dually eligible members residing in nursing facilities elect, revoke, and change hospice providers, and change addresses, under *both* the Medicaid and Medicare programs at the same time.
 - The IHCP does not require dually eligible hospice members residing in private homes to enroll in the Medicaid hospice benefit, because Medicare is paying for the hospice services. This same standard applies to dually eligible members residing in intermediate care facilities for individuals with intellectual disabilities (ICFs/IID), licensed residential care facilities enrolled as Medicaid assisted living providers, and Medicaid adult family care providers.
- *State Operations Manual, Section 2082*, and federal regulations under OBRA-89 require the hospice provider to submit the necessary certification paperwork to the State Medicaid agency. Because the dually eligible member elects, revokes, and changes a provider under both the Medicare and Medicaid programs, it is the hospice provider's responsibility to notify both Medicare and the IHCP about any change in the hospice member's hospice care status.
 - Failure to submit the necessary certification forms constitutes noncompliance with State and federal statute. See [Section 5: Hospice Authorization](#) in this module for more information about the required certification forms and the different situations in which a dually eligible member is enrolled in both programs.
- The hospice provider and the nursing facility must follow certain procedures to ensure compliance with *Indiana Administrative Code 405 IAC 1-16-4*. Failure to follow these procedures results in recoupment by the IHCP. See [Section 6: Billing and Reimbursement](#) in this module for more information about the procedures that the nursing facility and the hospice provider must follow.
- Additionally, hospice providers are required to coordinate regularly with NF providers. To ensure that the IHCP member's enrollment in the IHCP hospice benefit is clear to both hospice and NF staffs, the hospice provider must furnish the NF staff with the member's Medicaid hospice forms. The hospice must develop coordination procedures with the NF billing department to inform the NF of hospice care status.

Note: Among dually eligible members, only those with comprehensive Medicaid benefits (under either the Full Medicaid or Package A – Standard Plan) are eligible for IHCP hospice benefits. Members with only Qualified Medicare Beneficiary (QMB-Only), only Specified Low Income Medicare Beneficiary (SLMB-Only), Qualified Individual (QI), or Qualified Disabled Working Individual (QDWI) coverage are not eligible for IHCP hospice benefits. Additionally, dually eligible members with a liability must meet liability requirements each month before the full Medicaid coverage goes into effect; until then, they are considered QMB-Only or SLMB-Only. For more information, see the [Member Eligibility and Benefit Coverage](#) module.

Members Receiving Home and Community-Based Services

Home and Community-Based Services (HCBS) programs include the following:

- 1915(c) HCBS waiver programs
 - Under the Division of Aging:
 - Aged and Disabled (A&D) Waiver
 - Traumatic Brain Injury (TBI) Waiver
 - Under the Division of Disability and Rehabilitative Services (DDRS):
 - Community Integration and Habilitation (CIH) Waiver
 - Family Supports Waiver (FSW)
- 1915(i) State Plan HCBS programs
 - Under the Division of Mental Health and Addiction (DMHA)
 - Adult Mental Health Habilitation (AMHH)
 - Behavioral and Primary Healthcare Coordination (BPHC)
 - Child Mental Health Wraparound (CMHW)
- The DDRS Bureau of Developmental Disabilities Services (BDDS) State Line Services
- The Community and Home Option to Institutional Care for the Elderly and Disabled (CHOICE) program

HCBS programs are always the funding of last resort. This section clarifies when home health, hospice, and HCBS can be used in the delivery of services to mutual clients.

Note: The terms “client,” “participant,” “member,” “individual,” and “consumer” are used interchangeably within the Family and Social Services Administration (FSSA) and the divisions. Each term refers to the person actually receiving hospice, Medicaid State Plan, CHOICE, state-funded, or waiver services.

IHCP members who receive home and community-based services through one of the HCBS programs and who meet the hospice criteria are eligible for IHCP hospice services. HCBS program participants who choose the hospice benefit do not have to disenroll from the HCBS program and may continue to receive HCBS program services that are not related to the terminal condition and are not duplicative of hospice services.

Similarly, individuals who have elected the hospice benefit can also apply for and possibly receive HCBS program services that supplement the hospice services as long as those HCBS program services are not related to the terminal condition, do not duplicate hospice services, and are available through the applicable source.

The IHCP hospice provider must provide all required services to meet the needs of the member in relation to the **terminal** diagnosis. The number of hours related to the member’s **nonterminal** condition is determined on a case-specific basis. The member should not be provided with additional services other than those the IHCP program would have provided if the member had not elected hospice care.

The IHCP expects the hospice provider to coordinate with other, nonhospice providers to ensure that the member’s overall care is met and that nonhospice providers do not compromise the hospice plan of care. The hospice provider and the waiver case manager must collaborate and communicate regularly to ensure that the best possible care is provided.

It is appropriate for transition-related HCBS waiver services to be provided on the same day as long-term care client discharges. Provision of certain HCBS waiver services to clients with hospice level of care may also be appropriate. Payment for services provided under either of these circumstances will be systematically denied unless specially handled. Providers submitting claims for HCBS waiver services on the client’s date of discharge from the long-term care facility or during a period of hospice level of care should contact their Provider Relations field consultant for special claim handling. Providers that have had claims previously denied for these reasons should also contact their field consultant for special handling.

A member who is currently receiving hospice benefits may elect to discontinue those hospice benefits at any time and seek alternate means of meeting his or her healthcare needs.

It is very important that each member's medical condition is thoroughly reviewed and all viable options are discussed with the member so that an informed choice can be made.

For questions concerning HCBS waivers administered by the Division of Aging, contact 1-888-673-0002. Questions related to the DDRS Bureau of Developmental Disabilities Services (BDDS) waivers may be directed by email to BDDSPROVIDER@FSSA.IN.GOV. For questions related to HCBS services offered by the DMHA, call 1-800-901-1133.

Right Choices Program (Lock-In) Members

Right Choices Program (RCP) members are restricted to one physician, one pharmacy, and one hospital*, due to unnecessary or inappropriate use of the IHCP. RCP members are allowed to elect the IHCP hospice benefit. When the hospice election paperwork is completed, the member is disenrolled from the RCP.

**Note: The hospital lock-in requirement will be removed from the RCP program April 30, 2020.*

Members Residing in Group Homes

Medicaid-eligible group home members can elect the Medicaid hospice program. The hospice should bill the IHCP for the hospice services, and the group home can bill the IHCP for the group home per diem rate. Hospice and group home providers should coordinate the overall care for the group home member. It is the responsibility of the hospice to provide all hospice-covered services in frequency and scope to care for the terminal illness and related conditions. The hospice provider may not delegate any hospice core services to group home staff.

IHCP-Pending Individuals

The IHCP program cannot provide prior authorization for services for an individual who is not enrolled in the IHCP. An individual who is **not** enrolled in the IHCP when initiating hospice care is considered *private pay*.

If hospice providers choose to provide hospice care for an IHCP-pending individual, those providers do so at their own financial risk. The IHCP cannot guarantee that the individual meets all criteria to be IHCP-eligible or Medicare-eligible as of the date hospice care was initiated.

The Division of Family Resources (DFR) is the agency within the Indiana FSSA that has the authority to determine an individual's IHCP eligibility status. The hospice patient, or his or her representative, must apply for IHCP coverage [online](#), by telephone at 1-800-403-0864, or at a [local DFR office](#). The DFR state eligibility consultant assigned to review the hospice patient's Medicaid eligibility then notifies the applicant or the applicant's representative in writing of the eligibility decision.

If appropriate, the local DFR state eligibility consultant can establish the individual's IHCP eligibility 90 days before the date of the individual's IHCP application. If the DFR state eligibility consultant determines that the hospice patient is IHCP-eligible, the hospice patient receives written notification from the DFR state eligibility consultant that specifies the start date of the hospice patient's IHCP coverage. The DFR state eligibility consultant can establish eligibility even if an applicant has died during the application process.

The hospice analyst cannot review and approve the certification forms for an IHCP-pending individual. The hospice provider must hold all paperwork until the IHCP-pending individual is notified of IHCP eligibility. It is recommended that the hospice provider complete the IHCP hospice forms at the same time the agency completes its own hospice agency forms so that the forms are ready to submit to the PA contractor when IHCP eligibility is established. A hospice provider can determine the date of IHCP enrollment for an IHCP-

pending individual by checking the Portal, IVR system on a regular basis, using the patient's IHCP Member ID, Social Security number and birth date, or first and last name and birth date. The hospice provider can then submit the certification forms to the PA contractor.

Note: IHCP eligibility status can change for numerous reasons. It is recommended that the hospice provider verify IHCP eligibility of the IHCP hospice member on a regular basis by using one of the following methods: The IHCP Portal available online or the IVR system available by calling 1-800-457-4584. Detailed instructions about how to use these options are provided in the [Interactive Voice Response System](#) and [Member Eligibility and Benefit Coverage](#) modules. Providers can also use the 270/271 electronic transaction to verify IHCP eligibility.

IHCP Members without IHCP Nursing Facility Level of Care

For the IHCP to reimburse nursing facility care, including nursing facility room-and-board services for a hospice member, the nursing facility, Area Agency on Aging (AAA), or hospital must complete the Preadmission Screening and Resident Review (PASRR) process for the hospice member. The local AAAs serve as the primary point of entry for at-home residents seeking placement in a Medicaid-certified facility. All IHCP and non-IHCP applicants to IHCP-certified NFs are entered in the State's PASRR web-based system, and a Level I screen is completed to initiate the PASRR process. For individuals seeking Medicaid coverage of their NF stay or any individual triggering a Level II evaluation, a level-of-care (LOC) assessment is also completed. For more information about the process, see the [Long-Term Care](#) module and the Indiana PASRR provider manual (available from the [Indiana PASRR Tools and Resources](#) page at maximus.com).

When this process is completed, the Core Medicaid Management Information System (*CoreMMIS*) is updated with the NF LOC. Until there is an NF LOC in *CoreMMIS*, the DXC hospice analyst cannot process the hospice authorization for an NF resident who has elected hospice. If the hospice provider submits the request for hospice, the request is placed in a pending status until *CoreMMIS* reflects the nursing facility level of care. The hospice provider may also choose to hold all paperwork until the NF advises the hospice that the appropriate authorization has been obtained from the PASRR process.

NF providers are **not** required to initiate a new LOC screen when an NF resident elects, revokes, or is discharged from hospice care if the NF has a current NF LOC in *CoreMMIS*. The election, revocation, or discharge of an NF resident from the Medicare or IHCP hospice benefit does **not** constitute a change in NF LOC. The AAA performs on-site assessments for individuals who do not appear to meet NF criteria for a final determination prior to any denial.

The Division of Aging recommends the following procedures to determine whether a hospice member has nursing facility LOC in *CoreMMIS*:

- Develop coordination and notification procedures between the appropriate nursing facility staff and hospice staff about the approval of the PASRR and LOC screening for hospice members.
- Address the coordination and notification responsibilities between nursing facility and hospice staff in the hospice contracts with nursing facilities.
- Check the IVR system or the Portal to determine whether there is nursing facility LOC for private-home hospice members recently admitted to the nursing facility.
- Contact Customer Assistance toll-free at 1-800-457-4584 for hospice claim questions when the Remittance Advice (RA) reflects EOB code 2026 – *Member not eligible for the level of care for the dates of service and revenue codes billed*. The following information must be verified:
 - Verify that the hospice member, using the Member ID provided, has an NF LOC for the dates of service.
 - Determine when the NF LOC was entered into *CoreMMIS*. For example, if the hospice claim was processed March 9, 2020, but the NF LOC was not in *CoreMMIS* until March 10, 2020, the claim denied appropriately.

Hospice claims for room-and-board services pay only if *CoreMMIS* reflects hospice LOC and NF LOC for the dates of service the hospice provider is billing the IHCP when the claim is submitted and processed by the IHCP. If the hospice provider cannot resolve a hospice or NF LOC problem for a hospice member, the provider should contact the Long Term Care Help Desk at (317) 488-5094.

Obtaining IHCP Nursing Facility Level of Care for Individuals Who Die Shortly After Admission to the Nursing Facility

When an individual dies shortly after the NF placement, before the PASRR process is completed, the NF is still able to complete the LOC assessment through the State's web-based PASRR system. The NF must complete this process and advise the hospice provider so that the hospice provider can bill the IHCP for hospice room-and-board and bed-hold services. If this process is not completed, there is no mechanism for the IHCP to reimburse for room-and-board services billed under hospice revenue code 659. Because hospice revenue code 659 pays only room and board, the hospice provider's reimbursement is not affected, as Medicare reimburses for the hospice services. Hospice revenue codes 650 and 658 include reimbursement for the hospice per diem plus the room-and-board add-on for Medicaid-only members residing in nursing facility. When the NF does not complete the process, the hospice provider is precluded from billing the IHCP for the hospice per diem under hospice revenue codes 650 and 658.

Therefore, the IHCP has developed the following process to ensure payment of the hospice per diem through a non-claim-specific check:

- The hospice should fax a letter to DXC explaining that the contracted nursing facility does not intend to complete the PASRR process. The cover letter should include the name of the nursing facility, nursing facility provider number, and name and telephone number of a contact person at the hospice agency. The letter should be faxed to the DXC hospice analyst at (317) 488-5020.
- With the letter, the hospice provider should also fax a properly completed hospice claim reflecting the dates of service for which the hospice requires reimbursement for the hospice per diem.

Note: The 180-day claim filing limit does apply to this scenario, so it is imperative that the hospice biller check eligibility on a regular basis and communicate with the nursing facility regularly about the PASRR approval process for each hospice member.

Individuals in the Residential Care Assistance Program

The FSSA DA administers the Residential Care Assistance Program (RCAP). The program pays a rate to licensed county homes and residential care facilities to provide room, board, laundry, and minimal administrative direction to individuals who are at least 65 years of age, who are blind, or who have a disability. To be eligible for the RCAP, individuals must be Medicaid-eligible and require a degree of care less than that provided by a nursing facility licensed under *Indiana Code IC 16-28*. As such, RCAP members do not meet nursing facility level-of-care requirements. Also the RCAP rate does not reimburse for skilled nursing services.

IHCP-eligible individuals participating in the RCAP who reside in residential care facilities licensed by Indiana State Department of Health (ISDH) can elect the IHCP hospice benefit. However, the IHCP does **not** pay additional room and board for these individuals.

Individuals enrolled in the RCAP who reside in county homes are not eligible for the IHCP hospice benefit, as their eligibility category is Aid to Residents in County Homes (ARCH). ARCH individuals are not eligible for IHCP hospice benefits, as noted in this module.

For more information about the RCAP, or to obtain a current listing of facilities participating in the RCAP, contact the Division of Aging at (317) 234-2944 or 1-888-673-0002.

Programs and Aid Categories Ineligible for the IHCP Hospice Benefit

Individuals enrolled in the following programs are **not** eligible for the IHCP hospice benefit:

- Children's Special Health Care Services (CSHCS)
- Aid to Residents in County Homes (ARCH)

Additionally, members enrolled in the following IHCP benefit plans are **not** eligible for the IHCP hospice benefit:

- 590 Program (Members who move out of the state-operated facility to enter hospice are disenrolled from the 590 Program and may be enrolled in an IHCP program with hospice benefits.)
- Emergency Services Only (Package E)
- Emergency Services Only Coverage with Pregnancy Coverage (Package B)
- Family Planning Eligibility Program
- Medicaid Inpatient Hospital Services Only (for inmates)
- Presumptive Eligibility for Pregnant Women
- Qualified Medicare Beneficiary without full Medicaid coverage under another benefit plan (QMB-Only)
- Specified Low-Income Medicare Beneficiary (SLMB)

For more information about these benefit plans, see the [Member Eligibility and Benefit Coverage](#) module.

Section 4: Election, Discharge, and Revocation

This section describes the Indiana Health Coverage Programs (IHCP) hospice benefit requirements for hospice election, hospice revocation, and hospice discharge. The following topics are addressed:

- The IHCP forms that the hospice provider must complete and the procedures that hospice providers must follow to submit these forms to DXC
- The effect that proper paperwork completion by the hospice provider has on reimbursement to hospice providers and nonhospice providers
- The coordination responsibilities that the hospice provider has for providing copies of these forms to the nursing facility (NF) so that the NF staff can include copies of these forms in the IHCP hospice member's NF medical chart

Federal Mandate under Omnibus Budget Reconciliation Act 89

In states that have a Medicaid hospice benefit, the *Omnibus Budget Reconciliation Act of 1989* (OBRA-89) requires the state Medicaid agency to pay for room and board under the Medicaid hospice program for dually eligible (Medicare and Medicaid) hospice members residing in NFs. Medicare pays for the hospice services, and Medicaid pays for the member's room and board as a pass-through payment to the hospice provider. The hospice provider then pays the NF according to their contract, which means dually eligible hospice members must elect, revoke, be discharged from, and change hospice providers using the required forms of *each* program.

Hospice providers are reminded to pay close attention to this process, because the IHCP has noted that hospice providers do not consistently ensure that dually eligible hospice members residing in NFs complete the Medicaid hospice forms when they elect, revoke, are discharged from, or change hospice providers.

A Medicare beneficiary who elects hospice cannot remain in a Medicare-certified bed in the nursing facility. The IHCP is paying for a room-and-board pass-through to the hospice; therefore, the member must be in a Medicaid-certified bed.

Admission Procedures

It is the hospice provider's responsibility to provide the member with specific information about Medicare and IHCP hospice benefits and, on admission, to educate the member about the participant responsibilities in the hospice program. The following information should be provided in writing and verbally when admitting a member to a hospice program:

- Explanation of the benefits that a member waives under the hospice benefit, as noted in the [Election by Member](#) section of this module
- Explanation of what procedures constitute palliative versus aggressive treatments under the hospice program; for example, chemotherapy or radiation if the treatment is palliative rather than curative, and how the interdisciplinary team makes this decision
- Member's responsibility for seeking preapproval for all treatments not in the hospice plan of care
- Member's responsibility for bills incurred for treatments and services with a physician or facility not contracted with the hospice

Hospice providers should inform members of all services that are or are not covered under the hospice benefit.

Election by Member

Concurrent with the certification process (as described in the [Hospice Authorization Process](#) section), a member must elect hospice services by completing a *Medicaid Hospice Election* form (*State Form 48737 [R2/1-12]*) indicating a particular hospice provider. An example of the *Medicaid Hospice Election* form can be downloaded from the [Forms](#) page at in.gov/medicaid/providers.

The member or member's representative can designate an effective date for the election that begins with the first day of hospice care or any other subsequent day of hospice care. The individual cannot designate an effective date that is earlier than the date of election.

According to *United States Code 42 USC 1395d(d)(2)* and *Indiana Administrative Code 405 IAC 5-34-6(b)*, election to the Medicaid hospice benefit requires the member to waive the following:

- Other forms of healthcare for treatment of the terminal illness for which hospice care was elected or for treatment of a condition related to the terminal illness
- Services provided by another provider equivalent to the care provided by the elected hospice provider
- Hospice services other than those provided by the elected hospice provider or its contractors

Concurrent Care for Children Exception

Section 2302 of the *Affordable Care Act*, entitled "Concurrent Care for Children," was amended to allow hospice services to be provided to children without forgoing any other service to which the child is entitled under Medicaid for treatment of the terminal condition. This provision was effective upon enactment of the *Affordable Care Act* on March 23, 2010. Prior to the enactment of this law, curative treatment for the terminal illness ceased on election of the hospice benefit.

The IHCP covers hospice care for children under 21 years of age concurrent with all medically necessary curative treatment for the terminal illness. Both the hospice and curative care providers complete the *Medicaid Hospice Plan of Care for Curative Care – Members 20 Years and Younger* form (*State Form 54896 [2-12]*) available on the [Forms](#) page at in.gov/medicaid/providers. For additional information, see the [Plan of Care for Concurrent Hospice and Curative Care Services for Children](#) section of this document.

Nursing Facility Residents

For members residing in the NF, the IHCP encourages hospice providers to provide a copy of the *Medicaid Hospice Election* form to the NF to be included in the hospice member's NF clinical record. This ensures that the NF staff knows that the member has the IHCP hospice benefit, whether the member is a Medicaid-only member or a dually eligible (Medicare and Medicaid) member. To ensure better communication about reimbursement issues between the hospice and NF, the hospice must develop coordination procedures with the appropriate staff in the NF billing department so that the nursing facility biller is aware when the member elects, revokes, or is discharged from hospice care.

Medicaid-Only and Dually Eligible Members

The *Medicaid Hospice Election* form must be completed in its entirety for the Medicaid-only hospice member. If the member is a dually eligible (Medicare and Medicaid) member, the hospice provider must complete the one-page notification sheet, *Hospice Authorization Notice for Dually Eligible Medicare/Medicaid Nursing Facility Residents*, and attach a copy of the hospice agency election form reflecting the member's hospice election and the member's or the member's representative's signature. The dually eligible member is required to sign the *Medicaid Hospice Election* form as well, to ensure compliance with OBRA-89.

Revocation by Member

Hospice revocation is a **patient-initiated** process. Hospice providers should review *Code of Federal Regulations 42 CFR 418.28* to understand federal regulations about hospice revocation. The IHCP hospice benefit mirrors federal Medicare regulations and policy for hospice revocation.

Note: State Operations Manual, Section 2082.D specifies that in states that have a Medicaid hospice benefit, a dually eligible (Medicare and Medicaid) member residing in an NF must revoke hospice care under both the Medicare and Medicaid programs.

If a member, or representative of a member, is not satisfied with hospice care and wishes to revoke hospice services, the following procedures apply:

- The individual must sign a *Medicaid Hospice Revocation* form (State Form 48735 [4-98]/OMPP 0007). This form includes a signed statement that the individual revokes the election of IHCP hospice services for the remaining days in the election period.
- A member can elect to receive hospice care *intermittently*, rather than consecutively, over the three benefit periods. The member can therefore elect and revoke hospice coverage an unlimited number of times.
- If a member revokes hospice services at any point in the three benefit periods, time remaining in *that* benefit period is forfeited.
- If a member reelects the IHCP hospice benefit, the member returns as a *reenrollment* to the next eligible hospice benefit period. The hospice provider is required to submit the following forms to DXC Prior Authorization Unit, so that the DXC hospice analyst can *reenroll* the member into the next hospice benefit period:
 - *Medicaid Hospice Election* form (State Form 48737 [R2/1-12])
 - *Medicaid Hospice Physician Certification* form (State Form 48736 [R2/12-02]/OMPP 0006)
 - An updated plan of care

For example, if the individual revokes hospice care in the first hospice benefit period and then reelects, DXC starts the individual in the second hospice benefit period as of the date the individual signed the election form.

- The member or the member's representative must revoke hospice care in writing for the hospice revocation to be valid. Neither the Medicare nor the IHCP hospice benefit recognizes *revocation by action* when a hospice patient is noncompliant with the hospice care philosophy.
- The member or the member's representative must specify the date that hospice revocation is to be effective. It is the hospice provider's responsibility to ensure that the member or member's representative understands that an individual or individual's representative cannot designate an effective date earlier than the date the revocation is made, according to federal regulation *42 CFR 418.28(b)(2)*.
- If all hospice benefit periods preceding the date of the hospice revocation have been previously authorized, the hospice provider can fax the *Medicaid Hospice Revocation* form to DXC at 1-800-689-2759 or upload the completed form to the Provider Healthcare Portal (Portal) as a system update to the authorization. Until the hospice revocation is reflected in *CoreMMIS*, no other IHCP provider can bill the IHCP for services included in the IHCP hospice per diem. These nonhospice providers include, but are not limited to, the nursing facility where a member may be residing.
- For hospice members residing in an NF, hospice providers must provide a copy of the *Medicaid Hospice Revocation* form to the appropriate staff in the NF to ensure that the form is included in the hospice member's NF clinical record. This requirement ensures that the nursing facility has this legal document reflecting that the member revoked the Medicaid hospice benefits. These coordination procedures ensure that the NF staff is aware of the exact date the hospice member revoked hospice care. To ensure better communication about reimbursement issues between the

hospice and NF, the hospice must also develop coordination procedures with the appropriate staff in the NF's billing department so that the NF biller is aware when the member revoked hospice care. This permits the NF biller to submit claims for nursing facility care for the service date following the hospice revocation.

- The hospice provider must bill the IHCP for payment of the hospice per diem and for payment of the NF room and board for the date of the hospice revocation. The reason for this reimbursement guideline is that the individual is still under hospice care on that day. The NF can resume billing the IHCP directly for NF care for the date of service after the hospice revocation, after the hospice provider has provided them with a copy of the hospice revocation that has been processed by the DXC Prior Authorization Unit.

Discharge by Hospice Provider

The hospice *member* initiates hospice revocation, but the hospice *provider* initiates the process of hospice discharge. Prior to discharging a patient, the hospice must obtain a written physician's discharge order from the hospice medical director. If a patient has an attending physician involved in his or her care, this physician should be consulted before discharge and his or her review and decision included in the discharge note.

A hospice provider that wishes to discharge a member is required to file a *Medicaid Hospice Discharge* form (*State Form 48734 [R/12-02]/OMPP 0008*), available on the [Forms](#) page at in.gov/medicaid/providers. The hospice medical director or the patient care coordinator are the only individuals included in the hospice interdisciplinary team that may sign the *Medicaid Hospice Discharge* form. If safety is an issue, the Family and Social Services Administration (FSSA) requires notification, as indicated on the *Medicaid Hospice Discharge* form, of the circumstances surrounding the impending discharge.

If all hospice benefit periods preceding the date of the hospice discharge have been previously authorized, the hospice provider can fax this form to the DXC Prior Authorization Unit at 1-800-689-2759 or upload the completed form to the Portal as a system update to the authorization. A copy of the *Medicaid Hospice Discharge* form must also be sent to the member.

For members residing in nursing facilities, hospice providers are required to provide a copy of the *Medicaid Hospice Discharge* form to the appropriate staff in the NF to ensure that the form is included in the clinical record the NF maintains for the hospice member. This coordination ensures that staff is aware of the exact date the hospice provider discharged the member.

The following process must be followed:

- Hospice providers must bill the IHCP for the hospice per diem for NF room and board for the hospice discharge date.
- Nursing facilities may resume billing the IHCP directly for NF care for the dates of service following the hospice discharge date.

Hospice providers are reminded that it is a violation of medical records standards to predate the hospice discharge. The documented discharge date cannot precede the actual discharge date.

This discharge procedure applies for Medicaid-only members residing at home, Medicaid-only members residing in nursing facilities, and dually eligible (Medicare and Medicaid) hospice members residing in nursing facilities. Federal regulations require dually eligible hospice members residing in nursing facilities to elect, revoke, or change hospice providers, and to be discharged from hospice care, simultaneously under the Medicare and Medicaid programs, because state Medicaid agencies pay for these nursing facility residents' room and board, as required by OBRA-89 and state regulations at *405 IAC 1-16-4*. Hospice providers are required to submit the appropriate paperwork under each program. Dually eligible hospice members residing at home are not required to elect, revoke, or change hospice providers, or to be discharged from hospice care, under both programs, because Medicare pays for the hospice services and Medicaid has no room-and-board payment responsibilities.

The following federal regulation pertains to hospice discharge.

42 CFR 418.26 Discharge from Hospice Care

- (a) *Reasons for discharge.* A hospice may discharge a patient if:
- (1) The patient moves out of the hospice's service area or transfers to another hospice;
 - (2) The hospice determines that the patient is no longer terminally ill; or
 - (3) The hospice determines, under a policy set by the hospice for the purpose of addressing discharge for cause that meets the requirements of paragraphs (a)(3)(i) through (a)(3)(iv) of *42 CFR 418.26*, that the patient's (or other persons in the patient's home) behavior is disruptive, abusive, or uncooperative to the extent that delivery of care to the patient or the ability of the hospice to operate effectively is seriously impaired. The hospice must do the following before it seeks to discharge a patient for cause:
 - (i) Advise the patient that a discharge for cause is being considered;
 - (ii) Make a serious effort to resolve the problem(s) presented by the patient's behavior or situation;
 - (iii) Ascertain that the patient's proposed discharge is not due to the patient's use of necessary hospice services; and
 - (iv) Document the problem(s) and efforts made to resolve the problem(s) and enter this documentation into its medical records.
- (b) *Discharge order.* Prior to discharging a patient for any reason listed in paragraph (a) of this section, the hospice must obtain a written physician's discharge order from the hospice medical director. If a patient has an attending physician involved in his or her care, this physician should be consulted before discharge and his or her review and decision included in the discharge note.
- (c) *Effect of discharge.* An individual, upon discharge from the hospice during a particular election period for reasons other than immediate transfer to another hospice –
- (1) Is no longer covered under Medicare for hospice care;
 - (2) Resumes Medicare coverage of the benefits waived under *42 CFR 418.24(d)*; and
 - (3) May at any time elect to receive hospice care if he or she is again eligible to receive the benefit.
- (d) *Discharge planning.*
- (1) The hospice must have in place a discharge planning process that takes into account the prospect that a patient's condition might stabilize or otherwise change such that the patient cannot continue to be certified as terminally ill.
 - (2) The discharge planning process must include planning for any necessary family counseling, patient education, or other services before the patient is discharged because he or she is no longer terminally ill.

Discharge with Cause

The Medicare hospice rules contain a section regarding hospice discharge, including specific requirements for discharge with cause. The IHCP has the same documentation requirements for discharge with cause as noted in *42 CFR 418.26*. For discharge with cause, providers must follow the requirements outlined in *42 CFR 418.26(a)(3)* and submit the required documentation to the DXC Prior Authorization Unit.

Before the state Medicaid agency discharges an individual under this section, the hospice needs to complete the *Medicaid Hospice Discharge* form, check the box “Other” as the reason for discharge, specify “discharge for cause” in the explanation section, and attach the medical documentation that supports the discharge for cause requested by the hospice medical director.

If a patient has an attending physician involved in his or her care, the physician should be consulted before discharge and his or her review and decision included in the discharge note. If the member does not have an attending physician, that fact must be reflected in the medical documentation supporting discharge with cause. In those cases, the hospice medical director serves as the patient’s attending physician.

While the IHCP has provided specific documentation requirements for discharge with cause, the hospice may still have to coordinate with the Indiana State Department of Health (ISDH) Acute Care Unit for situations where a Medicare beneficiary’s safety is compromised. Hospice providers should contact the ISDH Acute Care Unit at (317) 233-7474 under those circumstances, as the ISDH is the Centers for Medicare & Medicaid Services (CMS) contracted agent for these case-specific coordination concerns. The CMS offers guidance in its *Medicare Benefit Policy Manual*, [Chapter 9](#), Section 20.2.3, regarding coordination recommendations.

The hospice must notify the Medicare contractor and State Survey Agency of the circumstances surrounding the impending discharge. The hospice may also need to make referrals to other relevant state/community agencies (i.e., Adult Protective Services) as appropriate.

Discharge order: Prior to discharging a patient for any reason other than a patient revocation, transfer, or death, the hospice must obtain a written physician's discharge order from the hospice medical director. If a patient has an attending physician involved in his or her care, this physician should be consulted before discharge and his or her review and decision included in the discharge note.

Effect of discharge: An individual, upon discharge from the hospice during a particular election period for reasons other than immediate transfer to another hospice —

- Is no longer covered under Medicare for hospice care;
- Resumes Medicare coverage of the benefits waived; and
- May at any time elect to receive hospice care if he or she is again eligible to receive the benefit.

Discharge planning: The hospice must have in place a discharge planning process that takes into account the prospect that a patient’s condition might stabilize or otherwise change such that the patient cannot continue to be certified as terminally ill.

The discharge planning process must include planning for any necessary family counseling, patient education, or other services before the patient is discharged because he or she is no longer terminally ill.

Once a patient is no longer considered terminally ill with a life expectancy of 6 months or less if the disease runs its normal course, Medicare coverage and payment for hospice care should cease. Medicare does not expect that a discharge would be the result of a single moment that does not allow time for some post-discharge planning. Rather, it would be expected that the hospice’s interdisciplinary group is following the patient, and if there are indications of improvement in the individual’s condition such that hospice may soon no longer be appropriate, then planning should begin. If the patient seems to be stabilizing, and the disease progression has halted, then it could be the time to begin preparing the patient for alternative care. Discharge planning should be a process, and planning should begin before the date of discharge.

In some cases, the hospice must provide Advanced Beneficiary Notification (ABN) or a Notice of Medicare Non-Coverage (NOMNC) to patients who are being discharged. See *Pub. 100-04, Medicare Claims Processing Manual, Chapter 30 “Financial Liability Protections,” Section 50.15.3.1*, for information on these requirements.

During those situations where a hospice provider feels that a member has demonstrated significant noncompliance with the hospice plan of care, the documentation standard outlined in the last paragraph of *Section 20.2.3* in [Chapter 9](#) of the *Medicare Benefit Policy Manual* must be followed. It is very important that a hospice provider perform the following:

- Have written clear admission policies.
- Inform the member of his or her responsibilities under the hospice benefit.
- Document thoroughly the issues of noncompliance before taking the concern to the Part A MAC or IHCP prior authorization contractor.

Nursing Facility Hospice Discharge

For hospice members residing in an NF, hospice providers are required to provide a copy of the *Medicaid Hospice Discharge* form to the appropriate staff in the NF to ensure that the form is included in the hospice member's NF clinical record. These coordination procedures ensure that the NF staff is aware of the exact date that the hospice provider discharged the member from hospice care. To ensure better communication about reimbursement issues between the hospice and NF, the hospice must develop coordination procedures with appropriate staff in the NF billing department so that the NF biller is aware that the member was discharged from hospice care and can resume billing the IHCP directly for NF care the date after the hospice discharge.

The hospice provider must bill the IHCP for the hospice per diem and for NF room and board for the date of the hospice discharge. The reason for this reimbursement guideline is that the individual is still under hospice care on that day. The NF can resume billing the IHCP directly for NF care for the date of service after the hospice discharge once the hospice provider has provided them with a copy of the *Medicaid Hospice Discharge* form that was processed by DXC.

Hospice providers must not bill the IHCP for room and board for the date of death of an NF resident. Current IHCP regulations for NF reimbursement state that the IHCP does not pay the NF for the date that an NF resident is physically discharged from the NF. For reimbursement purposes, an NF resident's date of death is equivalent to nonpayment for the date of the NF resident's physical discharge from the NF. The election of hospice care by an NF resident does not rescind the current NF reimbursement regulations for NF room-and-board services.

Patients Admitted to a Noncontracted Nursing Facility

If a member is admitted to a noncontracted nursing facility, the hospice must discharge the member from being under the hospice level of care (this does not mean the member is discharged from the nursing facility), as it does not have a written agreement required under *42 CFR 418.112(c)*.

Patients Admitted to Noncontracted Hospital

If a member is admitted to a noncontracted hospital, the hospice must discharge the member, as it does not have a written agreement required under *42 CFR 418.108(c)*. A hospice provider cannot continue to follow a patient and maintain professional management when the patient is admitted to a hospital that the hospice provider does not have a contract with and the patient was admitted with a diagnosis unrelated to primary hospice diagnosis. The hospice provider is required to have a contract with the hospital. If the patient is admitted for care related to the terminal illness, the hospice provider should try to work with the hospital to enter into a contract so that professional management can continue. Documentation of all efforts made and appropriate hospital personnel contacted to pursue a contract should be included in the patient record. If a contract cannot be obtained, discharge is appropriate.

Change in Hospice Provider

Federal regulations at *42 CFR 418.30(a)* specify that an individual or individual's representative can change, once in each election period, the designation of the particular hospice where hospice care is received. *42 CFR 418.30(b)* further specifies that this change of the designated hospice does not constitute a revocation of the election for the period when it is made. The FSSA is legislatively mandated to model the IHCP hospice benefit after the Medicare hospice benefit. As such, state regulations at *405 IAC 5-34-6(g)* mirror the federal regulations cited in this paragraph.

A member, or representative of the member, who is not satisfied with a hospice provider can change hospice providers during any benefit period. This change does not constitute a revocation of services. To change a designated hospice provider, the member, or the member's representative, must file a *Hospice Provider Change Request Between Indiana Hospice Providers* form (*State Form 48733 [R/12-02] OMPP 0009*). The hospice provider can fax this form to the DXC Prior Authorization Unit at 1-800-689-2759, as long as all hospice benefit periods preceding the date of the hospice revocation were previously authorized.

If the DXC hospice analyst discovers a hospice authorization for the same dates of service in *CoreMMIS* that have been authorized for another hospice provider, the DXC hospice analyst cannot process the hospice authorization submitted by the new hospice provider until this discrepancy is resolved. The DXC hospice analyst resolves this issue as follows:

*Note: For purposes of this explanation, **original hospice provider** refers to the provider that first provided hospice services to the IHCP hospice member under the IHCP hospice benefit but who never formally notified DXC of any discharge or transfer to another provider. **New hospice provider** refers to the provider that recently assumed the management of the IHCP member's hospice care.)*

- The new hospice provider that submitted the hospice authorization with the duplicate dates of service must coordinate with the original hospice provider that maintains the hospice authorization for duplicate dates of service. When the new hospice provider obtains the *Hospice Provider Change Request Between Indiana Hospice Providers* form, the new hospice provider must resubmit the *Hospice Provider Change Request Between Indiana Hospice Providers* form to DXC with the election packet. The DXC hospice analyst enters the day of the change in provider as the first day of that hospice benefit period.
- The original hospice provider and the new hospice provider must coordinate and agree on the discharge and admission date in advance. Coverage cannot overlap and must be continuous.
- For hospice members residing in an NF, hospice providers are encouraged to provide a copy of the *Hospice Provider Change Request Between Indiana Hospice Providers* form to the appropriate staff in the NF to ensure that the form is included in the hospice member's NF clinical record. This practice ensures that all NF staff members are aware of the change of hospice provider. To ensure better communication regarding reimbursement issues between the hospice and the NF, the hospice must develop coordination procedures with appropriate staff in the NF's billing department so that the NF's billing department is aware of the change in hospice provider.

Short Absences for Hospice Patients

To address short absences from the hospice program, the CMS allows hospices to contract with other hospices, both within the state and across state lines. The subcontracted hospice is required to implement the hospice plan of care developed by the contracting hospice, and the contracting hospice retains the professional management of the patient's care. The contract must follow the minimum criteria outlined in *42 CFR 418.100(e)*.

The in-state hospice provider has two options in handling short absences; the paperwork requirements are listed under each option.

Option 1

The hospice provider (Hospice A) can discharge the hospice patient from the hospice program and make arrangements in advance for the admitting date of the second hospice (Hospice B). If both providers are in Indiana, this step does not require a contract between the two hospices, because this would be treated as a discharge or transfer:

- Hospice A must complete the *Medicaid Hospice Discharge* form, located on the [Forms](#) page at in.gov/medicaid/providers. Note that the member is moving out of the service area, and specify which hospice is assuming the care during the short absence.
- Hospice A must also complete the *Hospice Provider Change Request Between Indiana Hospice Providers* form, located on the [Forms](#) page at in.gov/medicaid/providers, and have the patient specify that he or she is changing providers.
- Hospice B must also submit paperwork to ensure authorization of hospice care under its provider number. Hospice B should submit the following forms, all located on the [Forms](#) page at in.gov/medicaid/providers:
 - *Medicaid Hospice Election* form (or, for dually eligible members residing in an NF, the *Hospice Authorization Notice for Dually Eligible Medicare/Medicaid Nursing Facility Residents* form (State Form 51098 [3-03]/OMPP 0014) and the hospice agency election form)
 - *Medicaid Hospice Physician Certification* form (not required for dually eligible members)
 - *Medicaid Hospice Plan of Care* form (not required for dually eligible members)

Note: It is helpful if Hospice B also submits a copy of the Hospice Provider Change Request Between Indiana Hospice Providers form.

It is important to note that the IHCP does not authorize or reimburse out-of-state hospice providers for hospice care. A hospice agency should not use option 1 when setting up a short absence, as it puts the patient in a situation where he or she does not have IHCP hospice coverage. Option 2, noted in the following section, should be used in these circumstances.

Option 2

This option allows hospice providers to contract with other Indiana hospice providers or out-of-state hospice providers when the hospice patient moves out of the hospice's service area. In these situations, the hospice authorization continues under the hospice provider that submitted the original request for authorization to the IHCP prior authorization contractor, DXC. Follow these steps:

- The hospice must submit a *Change in Status of Medicaid Hospice Patient* form (State Form 48732 [4-98]/OMPP 0010), located on the [Forms](#) page at in.gov/medicaid/providers, to DXC. The hospice should state on the *Prior Authorization System Update Request Form* (or on the Portal system update request) that the hospice is contracting with another hospice to provide care during this short absence. DXC will document in the claim-processing system that another provider is rendering the hospice care.
- Hospice A (the contracting hospice) is responsible for ensuring that Hospice B continues to submit required paperwork each benefit period so there is no break in hospice coverage.
- When the member returns from the short absence, Hospice A should submit another *Change in Status of Medicaid Hospice Patient* form, notifying DXC of the patient's return.
- The contracting hospice does incur a liability while transporting the patient to the subcontracted hospice, so it is important that all liabilities be addressed by an attorney.

Medical Records Standards

The FSSA reminds hospice providers that the hospice agency's forms and the IHCP hospice forms are considered medical documentation, meaning they must adhere to medical records standards and are subject to the requirements under 42 CFR 418.104. Failure to comply with proper medical records standards may affect a hospice provider's licensure and accreditation status during a State hospice licensure survey.

The *National Hospice Organization's Hospice Operation Manual* (Kilburn, Linda H., 1997), on page 155, has clear medical record guidelines for all hospice providers as follows:

The hospice medical record is a legal document. As such, it must be organized, written legibly in pen or in type (no pencil) and without obliterations or embellishments. It should be completed in a timely fashion so that at any point during the time the patient or family is in the care of the hospice, the documentation accurately reflects current care plan, service being provided and the status of the patient or family unit. The hospice should develop policies governing the format, content, access, review procedures (including quality assurance and utilization review activities), and a determination of the length of time that a medical record must be retained.

The FSSA has noted the following noncompliance with medical records standards on IHCP hospice forms, as well as on the hospice agency forms submitted for dually eligible (Medicare and Medicaid) members:

- The use of correction fluid rather than the staff person appropriately correcting an error by crossing out the error and noting the staff person's initials by the cross-out
- Failure of the hospice personnel to sign or date the forms, including the hospice agency's physician certification or hospice plans of care that are submitted for dually eligible members
- Submitting a packet of paperwork that reflects hospice discharge on a particular date due to the hospice member's date of death, yet the hospice physician still signed the hospice certification form the date after this individual died, recertifying the individual for another hospice benefit period (reflects lack of review of the hospice medical chart by internal quality assurance reviewer)

Section 5: Hospice Authorization

Providers are to use current professional guidelines, including the Medicare Local Coverage Determination (LCD), to determine when hospice services meet medical necessity. The Indiana Health Coverage Programs (IHCP) recognizes that the LCD is only a guideline to determine when members may be appropriate for hospice or palliative services. The LCD is not meant to replace the overall clinical evaluation by the hospice provider, the IHCP, or its contractor, when evaluating the unique clinical condition of each hospice member.

For dually eligible (Medicare and Medicaid) hospice members, hospice providers should refer to eligibility requirements in *Code of Federal Regulations 42 CFR 418.20*, which states: “In order to be eligible to elect hospice care under Medicare, an individual must be: (a) Entitled to Part A of Medicare; and (b) Certified as being terminally ill in accordance with 418.22.”

Medicaid-only hospice members must be eligible for the Medicaid program and be certified as terminally ill in accordance with *42 CFR 418.22*. Furthermore, the medical documentation contained in the *Medicaid Hospice Physician Certification* form (*State Form 48736 [R/12-02]/OMPP 0006*) and the *Medicaid Hospice Plan of Care* form (*State Form 48731 [R/11-04]/OMPP 0011*) must support a terminal diagnosis versus a chronic condition.

Within the specific context of the hospice benefit, the hospice authorization process consists of the following two parts:

- Election, plan of care, and benefit period process
- Prior authorization (PA) for services not covered by the IHCP hospice per diem as described in *Indiana Administrative Code 405 IAC 5-34-8*

Submitting Hospice Authorization Requests

Note: For HIP and Hoosier Care Connect members, hospice authorization requests should be submitted to the appropriate managed care entity (MCE) or its designated PA contractor.

Hospice providers must submit all required forms for Traditional Medicaid (fee-for-service) hospice authorization to the DXC Prior Authorization Unit. The preferred and most efficient method for submitting prior authorization requests and documentation is through the [IHCP Provider Healthcare Portal](#), accessible from the home page at in.gov/medicaid/providers. However, providers can also submit PA request forms and documentation by fax to **1-800-689-2759** or by mail to the following address:

**Prior Authorization – FFS Medical
DXC Technology
P.O. Box 7256
Indianapolis, IN 46207-7256**

When applicable, DXC PA staff can coordinate with the managed care enrollment broker contractor to disenroll the member from managed care. The hospice-dedicated fax number for managed care disenrollment is (317) 810-4488. Hospice authorization starts the date after the member is disenrolled from managed care. Because DXC receives faxed prior authorization requests from all provider types, it is recommended that hospice providers follow up the fax with a telephone call to DXC at 1-800-457-4584, option 7, notifying DXC staff that a fax has been sent for disenrollment of a hospice member from managed care.

Election, Plan of Care, and Benefit Period Process

When an eligible member elects to receive services from a certified hospice provider, a plan of care must be developed. Unless the member is dually eligible for Medicare and Medicaid, the *Medicaid Hospice Plan of Care* form must be used. This form must be submitted to the DXC Prior Authorization Unit with the *Medicaid Hospice Election* form and the *Medicaid Hospice Physician Certification* form. See [Section 4: Election, Discharge, and Revocation](#) in this module for more information about the *Medicaid Hospice Election* form.

For concurrent hospice and curative care recipients, providers must submit an updated plan of care, including delineation of hospice and curative care services, to the DXC Prior Authorization Unit. The *Medicaid Hospice Plan of Care for Curative Care – Members 20 Years and Younger* form (*State Form 54896 [2-12]*) is available on the [Forms](#) page at in.gov/medicaid/providers to allow providers to include information related to the curative care services.

The following requirements apply to development of the plan of care:

- The interdisciplinary team member who drafts the plan must confer with at least one other member of the interdisciplinary team.
- One of the conferees must be a licensed physician or nurse, and all team members must review the plan of care.
- All the services stipulated in the plan of care must be reasonable and necessary for palliation or management of the terminal illness and related conditions.
- For concurrent hospice and curative care recipients, the Medicaid plan of care must include the information identified in this section, in addition to the following:
 - A coordinated plan of care must be prepared and agreed on by the interdisciplinary team and the providers rendering the curative care. The plan of care must include the following:
 - Assessment of the recipient's needs
 - Identification and delineation of the curative and hospice care services, including the scope and frequency of the services, and the manner in which the services and assessments are coordinated
 - Criteria for terminating the curative care services
- The plan of care and advance directive must be included in the medical charts, including providers rendering concurrent curative care treatment.
- The plan of care must be signed by the hospice medical director and include two signatures from any of the other disciplines listed on the *Medicaid Hospice Plan of Care* form. Failure to include the three required signatures results in return of the hospice authorization forms by DXC so that the hospice provider can make the required corrections.

In addition, the hospice provider must comply with *Section 1902(a)(57) of the Social Security Act*, whereby the hospice:

- Provides written information to patients about their rights under State law to make decisions concerning medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate advance directives
- Provides written information to individuals about the institution's or program's written policies regarding the implementation of the right to formulate an advance directive
- Documents in the patient's medical record whether an advance directive has been executed
- Complies with all advance directive requirements of State law
- Provides individual or group education on advance directives for staff and the community
- Prevents the placement of conditions on the provision of care as well as discrimination against an individual who has executed an advance directive

Benefit Periods

Hospice eligibility is available to qualifying IHCP-eligible members in three consecutive benefit periods. Table 3 lists the benefit periods.

Table 3 – Hospice Benefit Periods

Benefit Period	Eligibility
Period I	90 days
Period II	90 days (expected maximum length of time for illness to run its course)
Period III	Unlimited number of 60-day periods

For Medicaid-only hospice members, the *Medicaid Hospice Election* form, the *Medicaid Hospice Physician Certification* form, and the *Medicaid Hospice Plan of Care* form together constitute the basis for determination of the hospice authorization for the first benefit period. Assuming that information is sufficient and accurate, an initial benefit period of 90 days is approved.

If benefit periods beyond the first 90 days are necessary, for example Periods II or III, recertification on the *Medicaid Hospice Physician Certification* form and an updated *Medicaid Hospice Plan of Care* form are required for hospice authorization of the next benefit period requested. The *Medicaid Hospice Election* form does not need to be completed again unless the patient revoked hospice care or the hospice provider discharged the patient from hospice care and chose to resume hospice care at a later date. This process is represented in Table 4.

Table 4 – Hospice Authorization Process for Medicaid-Only Members

Time Period	Member Eligibility	Election	Hospice Authorization Process	
First 90 Days	<i>Medicaid Hospice Physician Certification</i> form (State Form 48736 [R2/12-02]/OMPP 0006): Box 1	<i>Medicaid Hospice Election</i> form (State Form 48737 [R2/1-12])	<i>Medicaid Hospice Plan of Care</i> form (State Form 48731 [R2/11-04]/OMPP 0011) for Period I 90 days →	Hospice authorization granted for first 90 days
Second 90 Days	<i>Medicaid Hospice Physician Certification</i> form (State Form 48736 [R2/12-02]/OMPP 0006): Box 2		<i>Medicaid Hospice Plan of Care</i> form (State Form 48731 [R2/11-04]/OMPP 0011) for Period II 90 days →	Hospice authorization granted for second 90 days
Subsequent 60-Day Periods	<i>Medicaid Hospice Physician Certification</i> form (State Form 48736 [R2/12-02]/OMPP 0006): Box 3		<i>Medicaid Hospice Plan of Care</i> form (State Form 48731 [R2/11-04]/OMPP 0011) for Period III 60 days →	Hospice authorization granted for next 60 days

Note: While the IHCP requires hospice providers to request PA for members at the beginning of each hospice benefit period, the IHCP and its contractors are not prevented from requesting medical documentation about any hospice member at any point during that member's enrollment in the IHCP. This practice is consistent with the IHCP Provider Agreement.

See [Section 4: Election, Discharge, and Revocation](#) for more detailed information about how to complete hospice authorization paperwork for dually eligible (Medicare and Medicaid) hospice members residing in a nursing facility and for Medicaid-only members in each of the three hospice benefit periods.

Criteria for Adequate Medical Documentation

Since the implementation of the IHCP hospice benefit, each prior authorization contractor has notified the State of concerns with hospice providers' medical documentation. The Family and Social Services Administration (FSSA) was advised by all IHCP PA contractors that hospice providers were submitting medical documentation for IHCP hospice authorization that was either incomplete in the required forms or was insufficient for the hospice analyst to confirm the ongoing terminal condition of the patient. Because all hospice providers are required to be Medicare-certified before the IHCP can enroll the hospice agency as an IHCP hospice provider, each hospice agency must ensure that the medical documentation submitted to DXC hospice authorization meets Medicare hospice conditions of participation.

When entering the third hospice benefit period of 60 continuous days, hospice providers must be as specific as possible about the medical documentation that supports the appropriateness of the individual's hospice care. If the DXC hospice analyst determines that the information is insufficient to process the request, the hospice analyst must request that the provider submit documentation required to process the request. The IHCP can request additional information when the documentation submitted by a provider is insufficient.

Medical documentation guidelines for hospice providers include the following:

- The individual must have a terminal prognosis as well as physician certification that meets the Medicare hospice conditions of participation (see the [Hospice Authorization Process](#) section of this document for a description of the certification requirements).
- The clinical evidence must support the terminal diagnosis at the time of the initial certification and at the time of each subsequent certification and must describe the patient's condition.
- Documentation must illustrate why the patient is considered terminal and not chronic. History is helpful when it provides clarification as to why the current documentation reflects only a chronic condition.
- Each patient's documentation must be specific to the individual and include any additional documentation that distinguishes this patient from other patients with the same disease who may be chronic but are not terminal.
- For each hospice benefit period, the interdisciplinary team must assess the patient's condition and hospice appropriateness, and the documentation must distinguish between exacerbation and stabilization, as well as between exacerbation and deterioration.
- The documentation must include the most specific and most terminal International Classification of Diseases (ICD) diagnosis code appropriate to the patient.
- The documentation must specify why any medication, treatments, or services that could be considered aggressive are considered necessary for the patient's palliative treatment.
- The patient's decline must be documented in detail.
- Providers must show how the systems of the patient's body are in a terminal condition.

The Centers for Medicare & Medicaid Services (CMS) and the Office of Inspector General (OIG) have expressed ongoing concerns regarding inadequate review of a hospice patient's status during the interdisciplinary team meetings for the third hospice benefit periods of 60 days. This inadequate review has resulted in the hospices receiving improper reimbursement for services provided to a patient who fails to continue to be eligible for the Medicare hospice benefit. Failure to document hospice care appropriateness, justifying reimbursement for Medicare and Medicaid, can result in recoupment of the appropriate hospice per diem by Medicare auditors for dually eligible hospice members, and recoupment from the IHCP per diem for Medicaid-only hospice members.

Note: 405 IAC 5-34-5 requires that a hospice physician or a hospice nurse practitioner must have a face-to-face encounter with a member receiving hospice care to determine continued eligibility for hospice care for the member's third benefit period and every benefit period thereafter. The face-to-face encounter must occur not more than 30 calendar days before recertification of the third benefit period and of every subsequent benefit period.

When approval for a benefit period is granted, a hospice provider can manage a patient's care at the four levels of care, according to the medical needs determined by the interdisciplinary team and the requirements of the patient, the patient's family, or primary care provider.

Note: Changes in levels of care do not require hospice authorization as long as these levels are rendered within a hospice benefit period that DXC has previously authorized.

Documentation Requirements for Hospice Members Residing in a Nursing Facility

For hospice members residing in a nursing facility, the IHCP, like the Medicare hospice program, requires hospice providers to coordinate on a regular basis with the NF provider. To ensure that the IHCP member's enrollment in the IHCP hospice benefit is clear to both hospice and NF staff, and compliant with medical records standards, the hospice provider must furnish the NF staff with the applicable Medicaid hospice forms to include in the member's chart.

For billing purposes, the hospice provider must inform the NF billing department of the dates of the hospice election, revocation, discharge, and change in hospice providers. It is the hospice provider's responsibility to develop the coordination procedures.

The following forms must be placed in the IHCP member's NF clinical record to clarify patient care and reimbursement issues:

- For the Medicaid-only hospice member:
 - *Medicaid Hospice Election form (State Form 48737 [R2/1-12])* with the hospice authorization stamp from the PA contractor
 - *Medicaid Hospice Physician Certification form (State Form 48736 [R2/12-02]/OMPP 0006)*
 - *Medicaid Hospice Plan of Care form (State Form 48731 [R2/11-04]/OMPP 0011)*
- For the dually eligible (Medicare and Medicaid) hospice member:
 - *Hospice Authorization Notice for Dually Eligible Medicare/Medicaid Nursing Facility Residents form (State Form 51098 [3-03]/OMPP 0014)*
 - Hospice agency election form
 - Coordinated plan of care prepared by the NF and the hospice providers
- *Medicaid Hospice Revocation form (State Form 48735 [4-98]/OMPP 0007)*
- *Medicaid Hospice Discharge form (State Form 48734 [R/12-02]/OMPP 0008)*
- *Hospice Provider Change Request Between Indiana Hospice Providers form (State Form 48733 [R/12-02] OMPP 0009)*
- *Change in Status of Medicaid Hospice Patient form (State Form 48732 [4-98]/OMPP 0010)*

See [Section 7: IHCP Recoupment](#) for information regarding quarterly recoupment for NF hospice providers.

Dually Eligible Members in Nursing Facilities

Dually eligible (Medicare and Medicaid) members residing in nursing facilities must elect, revoke, or change providers under *both* the Medicare and the IHCP programs at the same time. The hospice provider is required to notify both programs of any changes in the dually eligible member's hospice care status. The IHCP requires that the hospice provider submit all the required certification forms as described in [Section 3: Member Eligibility for Hospice Services](#) of this module.

The following paragraphs address different scenarios whereby a dually eligible member residing in an NF must be enrolled in both programs:

- An IHCP-eligible member already enrolled in the IHCP hospice benefit becomes eligible for Medicare benefits midway through IHCP hospice care. The hospice member must be enrolled in the Medicare hospice benefit at the same time of Medicare eligibility. In this situation, a *Change in Status of Medicaid Hospice Patient* form must be completed and submitted to the IHCP prior authorization contractor, DXC. This form indicates that the IHCP member is now eligible for Medicare. For such individuals, before the initiation of hospice care, hospice providers must make adequate preparation in the event the IHCP hospice member becomes Medicare-eligible.
- A dually eligible member declines Medicare hospice services, elects Medicare skilled nursing facility (SNF) care, exhausts the 100 days of Medicare NF care, and elects the Medicare hospice benefit. In this situation, dually eligible members who live in an NF must complete the required certification forms as described in this section, if Medicare benefits for NF care have been exhausted. The hospice provider must bill Medicare for the hospice services and then bill IHCP for 95% of the nursing facility case-mix rate for the NF room-and-board services.
- A dually eligible member residing in an NF has elected the Medicare hospice benefit and then becomes eligible for the IHCP. The dually eligible member must also be enrolled in the IHCP hospice benefit by completing the required certification forms, as described in this document. The hospice provider must bill Medicare for the hospice services and then bill the IHCP for 95% of the NF case-mix rate.

Clarification Regarding When the IHCP Can Mirror a Hospice Agency's Benefit Periods

The IHCP has been asked two questions regarding when the IHCP mirrors a hospice agency's benefit periods. To provide written clarification, this section provides a formal response to two case-specific scenarios.

Example 1: Medicare Beneficiary Residing at Home Who Is Admitted to the Nursing Facility

Scenario

A patient is a Medicare beneficiary who resides at home. The patient elects the Medicare hospice benefit on February 10, 2019. The patient is admitted to an NF February 28, 2019. When IHCP eligibility is established and the Preadmission Screening and Resident Review (PASRR) process is completed, the hospice member is deemed eligible for the IHCP. Appropriate forms are issued from the State's web-based PASRR system.

Question

Can DXC process the hospice authorization so the IHCP hospice benefit mirrors the Medicare hospice benefit periods by an agency?

FSSA Response

Yes. The IHCP hospice benefit periods mirror the Medicare hospice benefit periods.

- The IHCP processes all hospice authorization requests using the Julian calendar. Hospice care dates cannot overlap from one hospice benefit period to the next hospice benefit period in *CoreMMIS*.
- To facilitate the process for the DXC hospice analyst, the hospice provider must include a cover letter for DXC with a request that the hospice analyst have the IHCP hospice benefit periods mirror the Medicare hospice benefit periods. The hospice agency must include the following information in the cover letter:
 - The election or reelection date of the Medicare hospice benefit
 - A copy of the *Medicaid Hospice Election* form to validate the date the individual elected hospice
 - The IHCP hospice form with Sections A and B completed to reflect IHCP-required information
 - The *Change in Status of Medicaid Hospice Patient* form that explains the date the individual left home and was admitted to the nursing facility
 - The date the individual became IHCP-eligible

IHCP hospice benefit periods cannot be authorized before the date of IHCP eligibility.
Therefore, in this example, the DXC hospice analyst must enter February 28, 2019, as the start date of the IHCP hospice benefit.
- To have the hospice authorization end at the same time as the Medicare hospice benefit period, the DXC hospice analyst must perform the following review using the Julian calendar method:
 - Use the Medicare election date of February 10, 2019, to determine the end date of the Medicare hospice benefit period.
 - The initial Medicare election date of February 10, 2019, is Julian day 41.
 - Julian day 41 (February 10, 2019, or hospice election date) plus 90 days in first hospice benefit period equals Julian day 131 or May 11, 2019, which is the end date of first Medicare hospice benefit period.
 - IHCP hospice authorization is then granted from February 28, 2019, the start date of IHCP eligibility, through May 11, 2019, the end date of the first Medicare hospice benefit period.

Example 2: Hospice Patient with Private Insurance (such as Blue Cross and Blue Shield) Becomes IHCP-Eligible during a Hospice Benefit Period

Scenario

A hospice patient residing at home elects hospice January 31, 2019. The patient has private insurance and is **not a Medicare beneficiary**. The patient becomes IHCP-eligible February 10, 2019, and elects the IHCP hospice benefit on the same date by signing the *Medicaid Hospice Election* form.

Question

Can DXC process the hospice authorization so the IHCP hospice benefit period mirrors the start date of private insurance and the hospice agency does not have to track two sets of hospice benefit periods?

FSSA Response

No. The IHCP works with the hospice agency to authorize IHCP hospice benefit periods, which mirror the Medicare hospice benefit periods so the hospice agency does not have to track two sets of hospice benefit periods. However, a Medicaid-only hospice member cannot be tracked in the same manner because the member's enrollment date in the IHCP hospice benefit is not the same date as enrollment in the hospice agency's hospice program. In this example, the first IHCP hospice benefit period is authorized from February 10, 2019, the date of IHCP hospice election, through May 11, 2019.

Hospice Authorization Process

Specific criteria pertaining to prior authorization for hospice services may be found in 405 IAC 5-34-4. The PA information that follows is a guideline for determining procedures for hospice services requiring PA; however, see the *Indiana Administrative Code (IAC)* as the primary reference.

*Note: **PA is required** for any IHCP-covered service not related to the hospice member's terminal condition, if PA is otherwise required. **PA is not required** for pharmacy services (for conditions not related to the member's terminal condition), dental services, vision care services, or emergency services. For general information about requesting IHCP prior authorization, see the [Prior Authorization](#) module.*

Hospice providers must complete the *Indiana Health Coverage Programs Prior Authorization Request Form* or submit an authorization request via the IHCP Provider Healthcare Portal (Portal) when requesting hospice services for all members. All applicable forms, available in the *Hospice Forms* section of the [Forms](#) page at in.gov/medicaid/providers, must be submitted with the request, as follows:

- For Medicaid-only members, the following forms, must be completed and attached to the PA request:
 - *Medicaid Hospice Election* form – Indicates the IHCP member's willingness to choose the service
 - *Medicaid Hospice Physician Certification* form – Indicates the hospice member's prognosis and diagnosis that prompted hospice election
 - *Medicaid Hospice Plan of Care* form – Monitors treatment modalities and processes
- For dually eligible (Medicare and Medicaid) members residing in an NF, the following form must be completed and attached to the PA request:
 - *Hospice Authorization Notice for Dually Eligible Medicare/Medicaid Nursing Facility Residents* form
 - A copy of the hospice agency form showing the Medicare hospice election date

The forms may be submitted via the Portal, faxed to **1-800-689-2759**, or mailed to the following address:

**Prior Authorization – FFS Medical
DXC Technology
P.O. Box 7256
Indianapolis, IN 46207-7256**

The *Indiana Health Coverage Programs Prior Authorization Request Form* serves as a cover sheet for all hospice authorization requests submitted by mail or fax. This form can be found in the *Prior Authorization* section of the [Forms](#) page at in.gov/medicaid/providers. When submitting the request via the Portal, the forms can be uploaded as attachments. If the forms are not uploaded along with the Portal request, but sent separately by fax or by mail, the *Prior Authorization System Update Request Form* should be used as a cover sheet for the attachments.

Supporting documentation must also be submitted as required. The IHCP allows electronic signatures on supporting documents submitted with PA requests for home health and hospice services. An original signature or signature stamp is still required on the *Indiana Health Coverage Programs Prior Authorization Request Form*, as well as on all State forms submitted as attachments to the request, including the *Medicaid Hospice Physician Certification* form and the *Medicaid Hospice Plan of Care* form.

*Note: The IHCP recommends that hospice providers keep all IHCP hospice forms that reflect the original signature of the required parties and submit **copies** of these forms with the PA request. IHCP forms with original signatures are legal documents that reflect the member's enrollment in the IHCP hospice benefit and must be kept in the hospice member's clinical chart.*

The IHCP hospice provider must submit documentation to the DXC PA Unit within 10 days of the member's election effective date, and for each benefit period, for approval of the hospice benefit. The hospice analyst reviews the documentation for accuracy and completeness to authorize services for the requested period.

To facilitate paperwork for hospice providers and to minimize the possibility of auto-enrollment of hospice members between hospice benefit periods, the following policies are in effect:

- The hospice provider may complete and fax to DXC (or upload as attachments to a system update on the Portal) the *Medicaid Hospice Physician Certification* form and the *Medicaid Hospice Plan of Care* form 2 weeks before the start date of the recertification period.
- The hospice provider must assume responsibility for contacting the DXC hospice analyst before submitting the paperwork, so the DXC hospice analyst can be prepared for the paperwork's arrival.
- Paperwork is returned if not properly completed; providers should conduct their own quality assurance (QA) review to minimize paperwork being returned.

Hospice providers are required to use hospice revenue code 651 on all hospice authorization requests. The hospice authorization enables reimbursement at all IHCP hospice levels of care.

See [Table 5](#) for instructions on completing the *Indiana Health Coverage Programs Prior Authorization Request Form* for hospice requests. See [Table 6](#) for instructions on submitting the hospice PA request via the Portal.

Table 5 – *Indiana Health Coverage Programs Prior Authorization Request Form* Fields for Hospice Requests

Field	Description
Check the box of the entity that must authorize the service.	Select DXC Technology, the IHCP fee-for-service PA entity.
Patient Information: <ul style="list-style-type: none"> • IHCP Member ID (RID) • Date of Birth • Patient Name • Address • City/State/ZIP Code • Patient/Guardian Phone 	Enter the information requested for the member who is to receive the requested service. Required.
<ul style="list-style-type: none"> • PMP Name • PMP NPI • PMP Phone 	Enter the information requested for the member's primary medical provider (PMP), including National Provider Identifier (NPI). Required, if applicable.

Field	Description
Requesting Provider Information: <ul style="list-style-type: none"> • Requesting Provider NPI/ Provider ID • Taxonomy • Tax ID • Provider Name 	<p>Enter the information requested for each field. Required.</p> <p>Requesting medical providers should enter their National Provider Identifier (NPI). Atypical providers should enter their IHCP-issued Provider ID.</p> <p>The requesting provider NPI/Provider ID must be the billing NPI/Provider ID used by the provider or entity requesting the authorization:</p> <ul style="list-style-type: none"> • For a group/corporate entity, the requesting provider NPI/Provider ID is different from the rendering provider NPI/Provider ID. • For a sole proprietor, the requesting provider NPI/Provider ID and the rendering provider NPI/Provider ID will be the same. • For a dual-status provider, the requesting provider NPI/Provider ID and the rendering provider NPI/Provider ID may or may not be the same. <p>A valid NPI or Provider ID is required. If the requesting provider is not enrolled in the IHCP, the PA request will not be entered and the PA contractor (DXC) will notify the requesting provider by telephone.</p> <p>The provider's copy of the <i>Indiana Medicaid Prior Authorization Notification</i> (PA notification letter) is sent to the mail-to address on file for the requesting provider's NPI and Provider ID combination.</p>
Rendering Provider Information	Leave blank.
Preparer's Information	Leave blank.
Ordering, Prescribing, or Referring (OPR) Provider Information	Leave blank.
Medical Diagnosis	Leave blank.
Assignment Category	Make a checkmark in the Hospice box.
Dates of Service, Start	Enter the requested start date for the hospice benefit period. (For continued services, the start date must be the day after the previous end date.)
Dates of Service, Stop	Enter the requested end date of the hospice benefit period.
Procedure/Service Codes	<p>Enter hospice revenue code 651 only. Required.</p> <p>If any other revenue code is used, the DXC hospice analyst will return the request to the provider for correction.</p>
Modifiers	Leave blank.
Service Description	Enter the word hospice .
Taxonomy	Leave blank.
Place of Service (POS)	Leave blank.
Units	Leave blank.
Dollars	Leave blank.

Field	Description
Notes	Leave this section blank. Hospice analysts refer to other submitted documentation (such as the hospice election form, the physician certification form, and the plan of care) for required hospice authorization information.
Signature of Qualified Practitioner	Authorized provider, as listed in the <i>Provider Types Allowed to Submit PA Requests</i> section of the Prior Authorization module and 405 IAC 5-3-10, must sign and date the form. Signature stamps can be used. Required.
Date	

Table 6 – Provider Healthcare Portal Prior Authorization Request Fields for Hospice

Field	Description
Requesting Provider Information: <ul style="list-style-type: none"> • Provider ID • ID Type • Taxonomy • Name 	The requesting provider's information automatically appears in these fields based on the user that is logged into the Portal. The provider's copy of the <i>Indiana Prior Review and Authorization Request Decision</i> form is sent to mail-to address that corresponds to the Provider ID (or NPI and taxonomy) entered in this field.
Member Information: <ul style="list-style-type: none"> • Member ID • Birth Date • Last Name • First Name 	Enter the Member ID, date of birth, and at least the first character of the first and last name for the member who is to receive the requested service.
Rendering Provider Information: <ul style="list-style-type: none"> • Provider ID • ID Type • Taxonomy • Name • Service Type 	For Service Type, select Hospice . Leave all other fields in this section blank.
Message Information: <ul style="list-style-type: none"> • Message 	Use this field to note if attachments are being sent by mail or by fax, rather than uploaded to the Portal. A completed <i>Prior Authorization System Update Request Form</i> , including the PA number, must be included with the mailed or faxed attachments.
Diagnosis Information: <ul style="list-style-type: none"> • Diagnosis Type • Diagnosis Code 	Leave blank.

Field	Description
Service Details: <ul style="list-style-type: none"> • From Date • To Date • Code Type • Code • Modifiers • Units • Dollars • Place of Service • Message • Rendering Provider 	<p>In the From Date field, enter the requested start date of the hospice benefit period. (For continued services, the start date must be the day after the previous end date.)</p> <p>In the To Date field, enter the end date of the hospice benefit period.</p> <p>In the Code Type field, select Revenue Code.</p> <p>In the Code field, enter 651. If any other revenue code is used, the DXC hospice analyst will return the request to the provider for correction.</p> <p>In the Units field, enter the number of units being requested.</p> <p>Leave the remaining fields in this section blank. Hospice analysts refer to other submitted documentation (such as the hospice election form, the physician certification form, and the plan of care) for required hospice authorization information.</p>
Attachments <ul style="list-style-type: none"> • Transmission Method • Upload File • Attachment Type 	<p>FT-File Transfer is selected by default in the Transmission Method field.</p> <p>If uploading attachments electronically, click Browse and select the file to be uploaded to the Upload File field.</p> <p>In the Attachment Type field, select the type of document being uploaded.</p> <p>Click Add and repeat this process for each attachment being uploaded.</p>

Certification for Dually Eligible Hospice Members Residing in Nursing Facilities

Because the Part A MAC determines medical necessity for hospice care, the IHCP has opted to change the documentation requirements for IHCP hospice authorizations for members residing in NFs, for whom the IHCP pays for room-and-board services, as specified in *405 IAC 1-16-4*, and for whom Medicare pays for the hospice services. For these members, a one-page notification sheet, *Hospice Authorization Notice for Dually Eligible Medicare/Medicaid Nursing Facility Residents* (available on the [Forms](#) page at in.gov/medicaid/providers), permits DXC to enter the hospice authorization without evaluating medical necessity.

To ensure authorization, the provider must provide the information in each box of the notification form and confirm that the form is signed by the patient care coordinator. Blank boxes are not permissible. If a particular box does not apply, simply type **not applicable** or **NA**. Failure to properly complete the form results in suspension of the request and instructions for the provider to correct and resubmit the form.

A copy of the hospice agency form showing the Medicare hospice election date should be placed behind the *Hospice Authorization Notice for Dually Eligible Medicare/Medicaid Nursing Facility Residents* form.

These documents can be submitted by mail or fax or via the Portal, as described in the [Hospice Authorization Process](#) section. If the documentation is complete and correct, the hospice analyst authorizes the hospice services for the requested benefit period. The hospice provider receives a prior authorization notice with a hospice effective date and the hospice analyst's name. The prior authorization notice is the hospice provider's notification that claims can be submitted for that benefit period.

Hospice providers can contact the DXC Prior Authorization Unit at 1-800-457-4584, option 7 to speak to a hospice reviewer if they have any questions about form completion.

Certification for Medicaid-Only Hospice Members

The *Medicaid Hospice Physician Certification* form is used to certify that a member is terminally ill, with a prognosis of 6 months or less. The following medical personnel must complete this form:

- According to 42 CFR 418.22, the medical director or the physician member of the hospice interdisciplinary team *and* the attending physician must *both* sign the *Medicaid Hospice Physician Certification* form if the individual has an attending physician for the first hospice benefit period of 90 days. The hospice must submit one physician certification form with both signatures to the Medicaid PA contractor as proper medical documentation.
- For subsequent benefit periods, the hospice medical director or the physician member of the hospice interdisciplinary team must sign the physician certification.
- For cases when the member has no attending physician, the hospice provider must specify this in the box where the attending physician's signature is required.
- To expedite the processing of physician certification forms, the IHCP accepts a physician certification form with a faxed signature of the member's attending physician.

The following certification rules apply to the hospice benefit periods:

- The signed and dated *Medicaid Hospice Physician Certification* form must identify the diagnosis that prompted the client to elect hospice and must include a statement that the prognosis is 6 months of life or less. The physician signature alone is not sufficient to constitute a valid physician certification and results in suspension of the request until corrected forms are submitted.
- For Period I, the hospice provider must submit to the DXC Prior Authorization Unit written certification statements and a plan of care signed by the appropriate medical personnel, within 10 business days from the member's election effective date. Hospice providers are reminded the IHCP program guidelines require the signature of the hospice medical director and any of the two other disciplines listed in the *Medicaid Hospice Plan of Care State Form*. If the required signatures are not on the IHCP forms, the DXC hospice analyst suspends the hospice authorization paperwork for correction by the hospice provider. The subsection titled [*Hospice Plan of Care Documentation Requirements*](#) in this section provides more information about the content in the plan of care.
- For Periods II and III, the hospice provider must submit to the DXC Prior Authorization Unit, within 10 business days, a written recertification on the physician certification form and an updated plan of care prepared and signed by the appropriate medical personnel. Hospice providers are reminded the IHCP program guidelines require the signature of the hospice medical director and any of the two other disciplines listed in the *Medicaid Hospice Plan of Care* form. If the required signatures are not on the IHCP forms, the DXC hospice analyst suspends the hospice authorization paperwork for correction by the hospice provider.
- Exceptions to the 10-business-day time frame for hospice authorization paperwork, required for each of the hospice benefit periods, include IHCP-pending individuals or IHCP hospice members residing in an NF for whom CoreMMIS does not reflect NF LOC.

If the preceding requirements are not met, payment cannot be made for services rendered for that benefit period, because the hospice authorization process cannot be completed and no level of approval has been provided.

Expediting Attending Physician Signature

Since the implementation of the IHCP hospice benefit, the IHCP has indicated that it is permissible for hospice providers to fax the *Medicaid Hospice Physician Certification* form to the member's attending physician (AP) to obtain the AP's signature. The AP's office may return the faxed form to the hospice provider with the AP's signature, and the hospice provider can submit the completed form to DXC with all required documentation.

Certification Forms for Medicaid-Only Hospice Members

The IHCP requires hospice providers to use the IHCP hospice forms to enroll the Medicaid-only member in the IHCP hospice benefit. **No other forms are accepted in lieu of the IHCP hospice forms for Medicaid-only hospice members.**

This policy also applies to a Medicaid-only member who has private insurance (that may or may not cover hospice care), but who is not enrolled in the Medicare hospice benefit. Enrollment in the IHCP hospice benefit ensures that the IHCP covers, as the payer of last resort, any hospice services not covered by a Medicaid-only member's private insurance.

The certification forms can be submitted by mail or fax or via the Portal, as described in the [Hospice Authorization Process](#) section.

- If the certification forms are complete and correct, the hospice analyst authorizes the hospice services for the requested benefit period. The hospice provider receives a prior authorization notice with a hospice effective date and the hospice analyst's name. The prior authorization notice is the hospice provider's notification that claims can be submitted for that benefit period.
- If the forms are incomplete, the hospice analyst suspends the request and sends a letter asking the hospice to resubmit a copy of that form with the corrected information.

Hospice providers can contact the DXC Prior Authorization Unit at 1-800-457-4584, option 7 to speak to a hospice reviewer if they have any questions about form completion.

Hospice Plan of Care Documentation Requirements

Providers should see *42 CFR 418.56* for the pertinent regulations for the hospice plan of care.

The following information reminds providers of Medicare's requirements for the development of the plan of care. This information also includes clarification from the ISDH on questions regarding standing orders in nursing facilities and how to document provided-when-necessary (PRN) services.

- The plan of care must be established before rendering services. The plan of care must be dated on the day it is first established.
 - The basic interdisciplinary team member who first assesses the patient's needs must meet or call at least one other group member (nurse, physician, medical social worker, or counselor) before writing the initial plan of care. At least one of the persons involved in developing the plan of care must be a nurse or physician.
 - The other two members of the basic interdisciplinary team (attending physician and medical director) must review the initial plan of care and provide their input within 2 days of assessment. This input may be provided by telephone.
 - The plan of care must include an assessment of the individual's needs and identification of the services including the management of discomfort and symptom relief. It must state in detail the scope and frequency of services needed to meet the patient's and family's needs.

Note: Hospice providers are reminded, as the ISDH stated during an interdisciplinary group (IDG) meeting, that the hospice should note PRN times the number of visits. Frequency must be provided using the formula “range plus PRN.” Zero is not acceptable to use when establishing a range.

- The plan of care should include only services that are reasonable and necessary for the palliation and management of the terminal illness and related conditions:
 - The hospice interdisciplinary team (including consultation with attending physician and medical director) should decide which services are related or not related to the individual patient’s terminal condition.
 - The hospice interdisciplinary team decides what services are necessary for palliation and what services are considered curative, and therefore, noncovered (except for authorized curative treatment for children). Chemotherapy, radiation therapy, and other modalities may be used for palliative purposes if the hospice determines that these services are needed for palliation. This determination is based on the patient’s condition and the hospice’s caregiving philosophy. There is no additional Medicare (or Medicaid) reimbursement for these services.
- The plan of care must be reviewed and updated at intervals specified in the plan of care. It should be continually assessed to ensure the care the patient receives meets his or her needs and to verify that the patient continues to be appropriate for hospice benefits. The plan of care should be updated if the patient’s condition improves or deteriorates, and if the level of care changes.
- The plan of care sent to the Medicaid PA contractor must reflect all three signatures of the interdisciplinary team members on the same plan of care.

Plan of Care for Concurrent Hospice and Curative Care Services for Children

IHCP-enrolled children 20 years of age and under who elect the IHCP hospice benefit may also receive curative care services for the terminal condition concurrent with hospice care. Curative services must be medically necessary and included as part of the hospice plan of care submitted to the PA contractor.

When the IHCP member elects concurrent hospice and curative care benefits, the palliation and management of the terminal condition comes under the supervision of the IHCP hospice provider. Curative care services are covered separately from hospice services.

When a member elects concurrent hospice and curative care services, providers must develop a comprehensive plan of care. The plan of care is subject to the requirements outlined in *405 IAC 5-34-7* and must be:

- Prepared and agreed on by the hospice interdisciplinary team and the providers rendering the curative care. The plan of care must:
 - Provide an assessment of the member’s needs.
 - Identify and delineate the hospice and curative care services, and the manner in which the services and assessments are coordinated.
 - Identify the curative care services and hospice services, and the scope and frequency of the services.
 - Include the criteria for terminating curative care services.
- The plan of care must be reviewed and updated (as identified in the plan of care) and include:
 - Verification that the member’s needs are being met
 - Verification that the patient continues to be appropriate for hospice Medicaid benefit
- The plan of care should be updated if the patient’s condition improves or deteriorates, and if the level of care changes.
- The plan of care and advance directive must be included in the hospice and curative care provider’s medical charts.

Providers rendering curative services under the plan of care are responsible to obtain prior authorization for their services, when needed, and to bill for curative services. The hospice plan of care and the curative plan of care must be submitted to the IHCP prior authorization contractor to ensure a comprehensive review.

Additional Hospice Authorization Forms

The following forms are available from the *Hospice Forms* section of the [Forms](#) page at in.gov/medicaid/providers:

- *Hospice Provider Change Request Between Indiana Hospice Providers* form
- *Change in Status of Medicaid Hospice Patient* form
- *Medicaid Hospice Revocation* form
- *Medicaid Hospice Discharge* form

When submitting any of these forms by fax or mail, providers must complete a *Prior Authorization System Update Request Form* and attach it to the front of the appropriate completed form. The *Prior Authorization System Update Request Form* can be obtained from the *Prior Authorization* section of the [Forms](#) page at in.gov/medicaid/providers.

Alternatively, the requesting provider for the existing authorization may upload the appropriate form via the Portal as a system update to the authorization.

Timely Submission of Hospice Authorization Paperwork

Hospice providers are required to submit IHCP hospice authorization paperwork to the DXC Prior Authorization Unit within 10 business days of the effective date of the member's election of hospice services or within 10 business days of the beginning of the second and subsequent benefit periods. The signatures of the attending physician, the hospice medical director, and hospice interdisciplinary team members must be completed within the 10 business days for the hospice authorization request to be considered timely. The hospice authorization start date will be modified consistent with the late signature dates. Suspending a request for an additional 30 days does not mean the hospice provider has an additional 30 days to obtain required signatures and still be considered timely with regard to completion of the physician certification form and the hospice plan of care.

When there is insufficient information submitted to render a hospice authorization decision, or the documentation contains errors, a hospice authorization request is suspended for 30 days and the IHCP or its contractors request additional information from the provider. The provider must make the corrections and resubmit the proper documentation within 30 calendar days after the additional information or correction is requested. The provider must either submit an update form, noting the prior authorization number assigned to the original suspended request, or submit the additional information via the Portal as a system update to the original request. This process ensures that the subsequent request is not denied as a duplicate of the original request. **If the provider fails to resubmit the documentation with the appropriate corrections within the 30-day time period, the request for hospice authorization will be denied. The IHCP contractor must receive the request in the office within the 30th day for the request to be considered timely. The start date for hospice will be modified for untimeliness for hospice authorization requests for Medicaid-only and dually eligible hospice members residing in nursing facilities.**

If the provider submits additional documentation, within the 30-day time period, but the documentation submitted does not provide sufficient information to render a decision, the IHCP or its contractors can request additional information. The provider must submit the additional information within the additional 30 days. **If the provider fails to submit the requested information within the additional 30 days, or if the additional documentation does not provide sufficient information to render a decision, the request for hospice authorization will be denied.**

The hospice provider can appeal the denied hospice authorization.

Exceptions Related to Untimely Submissions

If a request for hospice authorization or supporting documentation is received after the time limits in this section, authorization can be granted only for services provided on or after the date that the request is received.

In following four case-specific circumstances, authorization can be granted for services furnished before the date of a request that does not comply with the time limits in this section:

- *Pending or Retroactive Member Eligibility:* The hospice authorization must be submitted within 12 months of the date of the issuance of the member's Hoosier Healthwise card.
- *Provider Unaware the Individual was Medicaid-eligible:* If the provider was unaware the member was eligible for services at the time services were rendered, hospice authorization is granted only under the following circumstances:
 - The provider's records document the member refused or was physically unable to provide the IHCP Member ID
 - The provider can substantiate that the provider continually pursued reimbursement from the patient until IHCP eligibility was discovered.
 - The provider submitted the request for prior authorization within 60 days of the date IHCP eligibility was discovered.
- *Pending or Retroactive Approval of Nursing Facility Level of Care:* The hospice authorization must be submitted within 12 months of the date nursing facility level of care was approved by the IHCP.
- *Review of Medical Necessity:* The IHCP relies on current professional guidelines, including the Medicare Local Coverage Determination (LCD), for hospice services.
 - The IHCP recognizes that the LCD is only a guide to assist in determining if a patient is appropriate for hospice care and is not meant to replace overall clinical evaluation by the hospice provider, or by the IHCP and its contractor, in evaluating the unique clinical condition of each hospice member. Each hospice authorization is reviewed as a stand-alone request, taking into consideration the hospice member's unique clinical history.
 - Hospice providers must adhere to the LCD published by the Part A MAC for the state of Indiana when evaluating a Medicaid-only hospice member for hospice care appropriateness.

In these four case-specific circumstances, an individual may be retroactively enrolled for IHCP hospice benefits. Retroactive consideration is given to benefit periods in which *CoreMMIS* does not reflect a current nursing facility level of care or member eligibility. Providers must check eligibility on a regular basis and must check eligibility each hospice benefit period. Subsequent benefit periods are not affected by eligibility or level-of-care status of previous benefit periods. For example, there was no nursing facility level of care for the first two hospice benefit periods for a hospice patient. The patient elected hospice January 2019. Nursing facility level of care was entered in the IHCP claim-processing system May 1, 2019. While the first two benefit periods would not have been processed due to lack of nursing facility level of care, the third hospice benefit period, starting in June 2019, should have had a timely submission.

Administration Reconsideration and Appeals Process for Hospice Authorization

IHCP members can appeal the denial or modification of hospice authorization under *405 IAC 1.1*.

Any provider submitting a request for hospice authorization that was denied, under this rule, can appeal the decision under *405 IAC 5-7* for administrative consideration of prior authorization decisions.

When insufficient information is submitted to render a decision, or the documentation contains errors, a hospice authorization is suspended pursuant to 405 IAC 5-34-4 and the IHCP or its contractor requests additional information from the provider. **Suspension is not a final decision on the merits of the request and cannot be appealed.** If the provider does not submit sufficient information within the time frames set out in 405 IAC 5-34-4(h), the request shall be denied. **Denial is a final decision and may be appealed pursuant to subsections (a) and (b).**

See the *Prior Authorization Administrative Review and Appeal Procedures* section of the [Prior Authorization](#) module for detailed instructions on the PA administrative review and appeals process.

Hospice Coverage and Authorization for Managed Care Members

As described in the [Managed Care Members](#) section of this module, hospice coverage and authorization procedures for managed care members varies based on program enrollment – HIP, Hoosier Care Connect, Hoosier Healthwise, or Program of All-Inclusive Care for the Elderly (PACE).

Note: Hospice providers must check IHCP eligibility to determine whether a member is enrolled in managed care. If the member is enrolled in Hoosier Healthwise or PACE, the hospice provider must immediately fax the Medicaid Hospice Election form to the DXC Prior Authorization Unit to initiate the member's disenrollment from managed care. Hospice providers who fail to follow this procedure will not receive payment for the dates of service that the IHCP member was still enrolled in managed care.

Hospice Services for HIP Members

Managed care entities (MCEs) cover both institution-based and in-home hospice benefits for members enrolled in HIP. Hospice authorization and claim billing for HIP members must be directed to the member's MCE – Anthem, CareSource, MDwise, or Managed Health Services (MHS). The hospice must ensure that it is enrolled within the member's MCE as a HIP provider.

Hospice Services for Hoosier Care Connect Members

All covered hospice benefits for members enrolled in Hoosier Care Connect are the responsibility of the enrolling MCE. Hoosier Care Connect members will remain enrolled with their MCE for the duration of the hospice period, regardless of whether the member receives in-home hospice care or institutional hospice care.

The hospice provider is responsible for coordinating all hospice services with the member's MCE, including obtaining PA and ensuring that the member has a nursing facility level of care, if the member will receive hospice services in an NF. Hospice authorization and claim billing for Hoosier Care Connect members must be directed to the member's MCE – Anthem or (MHS). The hospice must ensure that it is enrolled within the member's MCE as a Hoosier Care Connect provider.

The following responsibilities are determined by the type of inpatient stay:

- For inpatient stays **related to the terminal illness**, at the general inpatient hospice level of care or the inpatient respite hospice level of care, the hospice provider is responsible for the following:
 - Obtaining PA and reimbursing the facility
 - Obtaining contracts with all IHCP providers for arranged services
 - Paying the facility according to the contract between the hospice provider and the facility where the member receives care (*Note: The contract between the hospice provider and the facility covers all costs related to the terminal illness.*)

- Submitting claims directly to the MCE for reimbursement. (*Note: The hospice provider will be paid at the rate appropriate to the level of care provided to the hospice member; GIP hospice level of care will be reimbursed at the GIP rate and inpatient respite hospice level of care will be reimbursed at the respite rate.*)
- For members receiving inpatient care **unrelated to the terminal illness**, the facility is responsible for the following:
 - Obtaining PA, as required, from the MCE
 - Submitting claims directly to the MCE for reimbursement
 - All the member's care and treatment while the member remains at the facility

Hospice Services for Hoosier Healthwise Members

Hoosier Healthwise members must disenroll from managed care prior to receiving hospice benefits. Hoosier Healthwise members who elect to enroll in the IHCP hospice benefit become eligible for hospice care the day following disenrollment from the managed care program.

To facilitate the hospice authorization process, the hospice provider may fax the *Medicaid Hospice Election* form to the IHCP fee-for-service PA contractor, DXC, at (317) 810-4488 to initiate the disenrollment of the member from managed care. This DXC fax number is used only for managed care disenrollment.

It is imperative that hospice providers type **Hospice Member Disenrollment from Managed Care** in the subject line of the fax. After submitting the fax, hospice providers should call DXC to confirm that the hospice analyst received the fax. This practice ensures the disenrollment of the hospice member from managed care is completed in a timely manner and prioritized within the overall workflow.

On receipt of the enrollment information, the DXC hospice analyst contacts the appropriate person at MAXIMUS, the IHCP's managed care program enrollment broker, on the same day. The hospice provider may start billing the IHCP the day after the individual is disenrolled from managed care. Hospice providers are encouraged to communicate with DXC to make certain DXC can coordinate with MAXIMUS by 4 p.m. Eastern Time that same day to disenroll the member from managed care. Coordination by 4 p.m. allows ample time for MAXIMUS to process the disenrollment on that day.

The corresponding *Medicaid Hospice Physician Certification* form and *Medicaid Hospice Plan of Care* form must be sent to DXC within 10 business days, as outlined in 405 IAC 5-34-4 to ensure the request is timely. These forms can be faxed to DXC at 1-800-689-2759.

Special Batch Claims

The IHCP may special batch claims for hospice admissions when circumstances prevent same-day disenrollment from managed care as follows:

- Weekend or holiday admission when the member dies during that same weekend or holiday, and the hospice could not fax the *Medicaid Hospice Election* form to the DXC Prior Authorization Unit because DXC is closed:
 - The hospice must still meet the timeliness requirement of faxing the *Medicaid Hospice Election* form by the 4 p.m. deadline on the **first possible business day**.
 - For example, if the patient was admitted on Friday at 8 p.m., the *Medicaid Hospice Election* form must be faxed to DXC on the following Monday before the 4 p.m. deadline.

- One-day admission to the hospice program when the member dies on the day of admission, or is discharged from or revokes hospice care on the day of admission, and DXC could not have disenrolled the member even if the hospice faxed the form to DXC the day of admission:
 - The IHCP does not pay for room and board under the IHCP hospice benefit if the hospice member dies or is physically discharged from the nursing facility on the day he or she elected hospice.
 - When special-batch payment is warranted, the IHCP reimburses the hospice only for the hospice per diem.

To meet the parameters for the special-batch payment, the hospice must be able to:

- Produce a copy of the Medicaid eligibility verification strip demonstrating the hospice checked eligibility on admission per the *IHCP Provider Agreement*.
- Fax the *Medicaid Hospice Election* form and other paperwork to DXC on the first available business day so DXC can perform a review for medical necessity.
- Complete the paper *UB-04* claim form so that the FSSA may request that DXC process the claim by special batch.

The IHCP prior authorization contractor, DXC, notes on the prior authorization decision letter the authorized dates for hospice care. The hospice provider must fax the decision letter with a claim to the DXC hospice analyst at (317) 488-5020. The hospice analyst forwards the claim for special-batch processing. It is the responsibility of the hospice to develop internal procedures to ensure that the individual who receives the PA notice coordinates with the hospice biller on these payment issues. The hospice provider has 6 months from the date of the written request to submit the documentation and hospice claim to the FSSA for special-batch payment. If the provider does not submit the required documentation and hospice claim by the 6-month deadline, no expenditure payout is issued.

Program of All-Inclusive Care for the Elderly

PACE members are encouraged to discuss end-of-life care with their PACE care team and may request hospice or hospice-like services through their PACE program.

If a PACE member elects IHCP hospice benefits, he or she must be disenrolled from PACE and enrolled in Traditional Medicaid. PACE members must adhere to the PACE program's voluntary disenrollment process, and the PACE provider is responsible for coordinating services with new providers, including the hospice provider, to ensure a smooth transition. All PACE disenrollments take effect at the end of the last day of the month in which disenrollment is elected. Hospice and other IHCP services can begin on the first day of the following month.

Prior Authorization for Treatment of Nonterminal Conditions

Except as described in the following paragraph, prior authorization (PA) is required for any IHCP-covered service not related to the hospice member's terminal condition. The IHCP provider billing for the treatment of the nonterminal condition is responsible for obtaining the PA. A written PA request for treatment of the nonterminal condition must fulfill all the requirements specified in *405 IAC 5-3-5*. For more information about IHCP PA, see the [Prior Authorization](#) module.

Notwithstanding any other provision under this section, PA is not required for the following services when provided to hospice patients:

- Pharmacy services for conditions not related to the patient's terminal condition, except as described in the following note. Pharmacy services related to the patient's terminal condition are included in the hospice per diem.

Note: A prescriber's indication of brand medically necessary for a prescribed drug requires PA. This means that, if a prescriber chooses to specify brand medically necessary for a drug, PA must be obtained for the brand name drug before the pharmacist can be paid for the brand name drug. This action implements 405 IAC 5-24-8.

- Dental services
- Vision care services
- For IHCP-enrolled hospice members age 20 or younger – curative care services that do not otherwise require PA, as described in [Billing and Reimbursement for Concurrent Hospice and Curative Care for Children](#)

Note: The PA contractor must review requests for payment of services outside the per diem rates established within the context of the plan of care on a case-by-case basis.

See [Treatment for the Hospice Member's Nonterminal Condition](#) in Section 6: Billing and Reimbursement, for information about coordinating and billing services to treat nonterminal conditions in IHCP hospice members.

Request for Home Health Service Reimbursement in Addition to the Hospice Per Diem

The IHCP has directed that a member age 21 or older who is enrolled in the IHCP hospice benefit cannot concurrently receive IHCP home health services (outside those that are reimbursed under the hospice per diem) for treatment of the terminal diagnosis or related conditions. This IHCP policy is consistent with Medicare program guidelines. IHCP members age 21 or older must determine which services best meets their needs.

The PA contractor denies requests for home health hours for treatment of an IHCP hospice member's terminal illness that is duplicative of hospice care.

If the PA contractor receives a request for additional home health hours for treatment of the *nonterminal* condition, the request must fulfill all the requirements in 405 IAC 5-3-5. The following criteria must clearly appear on the written PA request to ensure that the request is not suspended for additional information:

- Written diagnosis and ICD code for the terminal and the nonterminal illness required
- Thorough explanation of the medical necessity that clearly documents that there is no relationship between the terminal illness and the required or requested home health treatments outlined in the PA request

The IHCP has the same standards as the Medicare hospice program, in that each provider must thoroughly document that there is no relationship between the terminal illness and the required home health treatments. If the IHCP determines during a postpayment review that the services are related, the hospice provider is liable for all services rendered.

It is important to note that the hospice provider must submit both the hospice plan of care and the home health plan of care to the PA contractor to ensure a comprehensive review.

A member age 20 or younger who elects hospice care may receive concurrent curative treatment in conjunction with hospice services for the terminal illness. This provision allows the member or member's representative to elect the hospice benefit when the need for hospice care is certified by a physician, without forgoing any curative service to which the child is entitled under Medicaid for treatment of the terminal condition.

Note: If a provider has prior authorization and the claim denies for recipient ineligible, the provider needs to work with a Provider Relations field consultant.

Clarification to Hospice Agencies about Hospice Authorization and Hospice Billing for a Hospice Member Discharged from the Hospital

This section provides policy clarification for those hospice agencies whose corporation also has a distinct home health agency.

When an IHCP *home health* member is discharged from the hospital to return home, the IHCP provides the home health agency with a 30-day grace period from the date of the hospital discharge to submit a request for IHCP PA to DXC. However, this policy does **not** apply to the IHCP *hospice* member. The hospice provider is required to submit the IHCP hospice authorization request within 10 days of the date of hospice election or the start date of a hospice benefit period, regardless of whether the member elects hospice in the hospital or was admitted to the hospital during a hospice benefit period.

Hospice providers must ensure that the provision of hospice services is consistent with all Medicare hospice conditions of participation, including the requirement that the hospice have a contract with the hospital stipulating that the hospice is the manager of the individual's hospice care, as described in *42 CFR 418.100(e)*. For more information regarding this subject, see the policy directive found in the [Hospice Providers' Contractual Responsibilities as the Professional Manager of a Member's Hospice Care](#) section.

Submission of the *Medicaid Hospice Discharge* Form and DXC Authorization Procedures

All IHCP-enrolled hospice providers are required to notify the IHCP of a member's date of death. To facilitate paperwork for IHCP-enrolled hospice providers and to ensure that DXC staff time is maximized when processing hospice paperwork for new hospice members and recertifications, the FSSA has provided a directive to DXC:

- The DXC hospice analyst processes the hospice certification paperwork. If *CoreMMIS* has a date of death on the member eligibility screen, the DXC hospice analyst enters the date of death at the time of the initial hospice certification or the processing of hospice recertifications if the forms have been properly completed to meet IHCP program guidelines. The date of death in *CoreMMIS* is provided by the local DFR state eligibility consultant.
- The DXC hospice analyst suspends the paperwork with a prior authorization notice requesting the hospice provider submit the *Medicaid Hospice Discharge* form retroactively to DXC.

If the date of death entered by the DXC hospice analyst does not match the date of death recorded by the hospice provider, it is the responsibility of the hospice provider to coordinate with the local DFR office to correct this discrepancy. The local DFR office requires the death certificate to correct this matter. The local DFR office has procedures in place to contact the Indiana Eligibility Determination and Services System (IEDSS) or Indiana Client Eligibility System (ICES) help desk if the problem cannot be corrected at the local DFR office. When the discrepancy is corrected, the hospice provider can request a correction of the hospice authorization from DXC. Hospice providers can obtain [contact information for the DFR](http://in.gov/fssa/dfr) at in.gov/fssa/dfr.

IHCP-enrolled hospice providers are encouraged to review current procedures to ensure hospice staff does not incorrectly submit *Medicaid Hospice Discharge* form for members not enrolled in the IHCP hospice benefit.

Hospice Authorization Guidelines for Comorbid Conditions

Hospice care is dependent upon a physician certification stating a member's prognosis of life expectancy is 6 months or less, if the terminal illness runs its normal course. In addition, the services provided in hospice care must be reasonable and meet medical necessity for the palliation or management of the terminal illness. Coverage for hospice care is strongly dependent on documentation of the member's condition as recorded in the provider's records. Documentation is used in the prior authorization and review process to determine the presence of medical necessity. Each case will be evaluated on its own merit. The existence of documented comorbidities, as well as the documentation of decline in the member's health status, is used in the evaluation. Existence of a patient advance directive should also be taken into consideration.

The IHCP uses existing medical documentation submitted by the hospice provider to determine medical necessity for hospice. Existing labs and other forms of medical tests may be helpful in determining appropriateness of hospice care and may be requested of the provider if such documentation exists; however, the IHCP would not expect the patient to undergo invasive tests at the end of life unless absolutely necessary to validate a prognosis. The IHCP and its contractors are not prevented from requesting medical documentation about any hospice member at any point during that member's enrollment in the IHCP. This practice is consistent with the *IHCP Provider Agreement*.

The criteria in the following sections serve as a guideline to assist in determining medical necessity of hospice services for persons with various medical conditions.

Amyotrophic Lateral Sclerosis (ALS)

The following information is for general diagnosis and consideration of medical necessity for ALS:

- ALS tends to progress in a linear fashion over time; therefore, the overall rate of decline in each patient is fairly constant and predictable, unlike many other noncancerous diseases.
- No single variable deteriorates at a uniform rate in all patients; therefore, multiple clinical parameters are required to judge the progression of ALS.
- Although ALS usually presents in a localized anatomical area, the location of initial presentation does not correlate with survival time. By the time patients become end-stage, muscle denervation has become widespread, affecting all areas of the body, and initial predominance patterns do not persist.
- Progression of disease differs markedly from patient to patient. Some patients decline rapidly and die quickly; others progress more slowly. For this reason, the history of the rate of progression in individual patients is important to predict prognosis.
- In end-stage ALS, the following two factors are critical in determining prognosis:
 - Ability to breathe
 - Ability to swallow

The ability to breathe can be managed by artificial ventilation, and the ability to swallow by gastrostomy or other artificial feeding, unless the patient has recurrent aspiration pneumonia. While not necessarily a contraindication to hospice care, the decision to institute artificial ventilation or artificial feeding will significantly alter a 6-month prognosis.

- Examination by a neurologist within 3 months of assessment for hospice is advised, to confirm the diagnosis and to assist with prognosis.

- The member must demonstrate a rapid progression of ALS within the 12 months preceding initial hospice certification. All the following clinical findings document this progression:
 - Progression from independent ambulation to wheelchair, or to bed-bound status
 - Progression from normal to barely intelligible or unintelligible speech
 - Progression from normal to pureed diet
 - Progression from independence in most or all activities of daily living (ADLs) to needing maximum assistance by caretaker in all ADLs
- The member must demonstrate critically impaired breathing capacity by the following characteristics occurring within 12 months preceding initial hospice certification. Presence of any of the following support a terminal illness status:
 - Vital capacity less than 30% of normal
 - Significant dyspnea at rest
 - Requiring supplemental oxygen at rest
 - Patient declines artificial ventilation
- The member must demonstrate critical nutritional impairment by all the following characteristics occurring within 12 months preceding initial hospice certification:
 - Oral intake of nutrients and fluids insufficient to sustain life
 - Continuing weight loss
 - Dehydration or hypovolemia
 - Absence of artificial feeding methods
- The member must demonstrate life-threatening complications by one of the following characteristics occurring within 12 months preceding initial hospice certification.
 - Recurrent aspiration pneumonia (with or without tube feedings)
 - Upper urinary tract infection, such as pyelonephritis
 - Sepsis
 - Fever recurrent after antibiotic therapy

Only one ICD diagnosis code is appropriate and can be used for ALS hospice services. See *Hospice Services Codes*, accessible from the [Code Sets](#) page at in.gov/medicaid/providers.

Alzheimer's Disease and Related Disorders

Alzheimer's disease and related disorders must support a prognosis of 6 months or less for hospice services to be considered medically necessary. The identification of specific structural impairments, functional impairments, and relevant activity limitations serve as the basis for palliative interventions and care planning.

The structural and functional impairments associated with a primary diagnosis of Alzheimer's disease may be complicated by comorbid or secondary conditions:

- **Comorbid Conditions** – The significance of a given comorbid condition is defined by the structural and functional impairments together with any limitation in activity related to the comorbid condition.

Ultimately, the combined effect of the Alzheimer's disease (stage 7) and any comorbid condition should be such that most members with Alzheimer's disease and similar impairments would have a prognosis of 6 months or less.
- **Secondary Conditions** – Secondary conditions, such as delirium and pressure ulcers, are directly related to a primary condition. Secondary conditions may be described by defining the structural or functional impairments together with any limitation in activity, or related to the secondary condition.

The occurrence of secondary conditions in members with Alzheimer's disease may be facilitated by the presence of impairments in body functions such as mental functioning and movement functions. Such functional impairments may contribute to the increased incidence of secondary conditions such as delirium and pressure ulcers.

Secondary conditions themselves may be associated with a new set of structural or functional impairments that may respond to treatment. The combined effects of the Alzheimer's disease and any secondary condition may indicate a prognosis of 6 months or less.

Documentation of structural impairments, functional impairments, and activity limitations facilitates the selection of intervention strategies and provides objective criteria for determining the effects of such interventions.

Note: The Reisberg Functional Assessment Staging (FAST) Scale may be used to assess the functional level of members with Alzheimer's disease and establish a prognosis of 6 months or less. Members who have a FAST score of 7 and specific comorbid or secondary conditions, may meet medical necessity.

Appropriate ICD diagnosis codes for Alzheimer's disease and related diagnoses that may meet medical necessity for hospice services are included in *Hospice Services Codes*, accessible from the [Code Sets](#) page at in.gov/medicaid/providers.

Cardiopulmonary Disease

Cardiopulmonary conditions are associated with impairments, activity limitations, and disability. Their impact on any given individual depends on the individual's overall health status. Cardiopulmonary conditions may support a prognosis of 6 months or less under many clinical scenarios.

The health status changes associated with cardiopulmonary conditions can be characterized using categories contained in the International Classification of Functioning, Disability, and Health (ICF). The ICF contains domains (for example, structures of cardiovascular and respiratory systems, functions of the cardiovascular and respiratory system, communication, mobility, and self-care) that allow for a comprehensive description of an individual's health status and service needs. Information addressing relevant ICF categories, defined within each of these domains, should form the core of the clinical record and be incorporated into the care plan, as appropriate.

Additionally, the care plan may be impacted by relevant secondary or comorbid conditions:

- **Comorbid Conditions** – Comorbid conditions affecting beneficiaries with cardiopulmonary conditions are, by definition, distinct from the primary condition itself. An example of a comorbid condition would be end-stage renal disease (ESRD).

The significance of a given comorbid condition is best described by defining the structural/functional impairments – together with any limitation in activity and restriction in participation – related to the comorbid condition. For example, a beneficiary with a primary cardiopulmonary condition and ESRD could have specific ESRD-related impairments of water, mineral, and electrolyte balance functions coexisting with the cardiopulmonary impairments associated with the primary cardiopulmonary condition, such as aortic stenosis, chronic obstructive pulmonary disease, or heart failure.

Ultimately, to support a hospice plan of care, the combined effects of the primary cardiopulmonary condition and any identified comorbid conditions should be such that most beneficiaries with the identified impairments would have a prognosis of 6 months or less.

- **Secondary Conditions** – Cardiopulmonary conditions may be complicated by secondary conditions. Secondary conditions are directly related to a primary condition. In the case of cardiopulmonary conditions, examples of secondary conditions could include delirium, pneumonia, stasis ulcers, and pressure ulcers.

The significance of a given secondary condition is best described by defining the structural/functional impairments – together with any limitation in activity and restriction in participation – related to the secondary condition. The occurrence of secondary conditions in beneficiaries with cardiopulmonary conditions results from the presence of impairments in such body functions as heart/respiratory rate and rhythm, contraction force of ventricular muscles, blood supply to the heart, sleep functions, and depth of respiration. These impairments contribute to the increased incidence of secondary conditions such as delirium, pneumonia, stasis ulcers, and pressure ulcers observed in Medicaid beneficiaries with cardiopulmonary conditions. Secondary conditions themselves may be associated with a new set of structural/functional impairments that may or may not respond/be amenable to treatment.

Ultimately, to support a hospice plan of care, the combined effects of the primary cardiopulmonary condition and any identified secondary conditions should be such that most beneficiaries with the identified impairments would have a prognosis of 6 months or less.

The identification and documentation of relevant secondary and comorbid conditions, together with the identification and description of associated structural/functional impairments, activity limitations, and environmental factors, help establish hospice eligibility and maintain a beneficiary-centered plan of care.

Heart Disease

For hospice services to be considered medically necessary for members with heart disease, the member must have current findings from numbers 1 and 2 in the following list. Findings from 3 are primarily supportive documentation for medical necessity.

1. The member has been treated with diuretics and vasodilators, which may include angiotensin-converting enzymes (ACE) inhibitors or the combination of hydralazine and nitrates. If side effects, such as hypotension or hyperkalemia, prohibit the use of ACE inhibitors or the combination of hydralazine and nitrates, the documentation submitted must reflect this reasoning. If a member, at rest, has angina pectoris that is resistant to standard nitrate therapy and the member is not a candidate for or declines invasive procedures, these factors must be documented in the medical records.
2. The member has significant findings of recurrent congestive heart failure at rest and is classified as New York Heart Association (NYHA) Class III or IV. Class III or IV patients with heart disease have an inability to carry on any physical activity without discomfort. Symptoms of heart failure or of the anginal syndrome may be present even at rest. If any physical activity is undertaken, discomfort is increased. Class III heart failure (moderate) is defined as the marked limitation of physical activity. Comfortable at rest, but less than ordinary activity causes fatigue, palpitation, or dyspnea. Class IV heart failure (severe) is defined as the inability to carry out any physical activity without discomfort along with symptoms of cardiac insufficiency at rest. If any physical activity is undertaken, discomfort increases. Congestive heart failure may be documented by an ejection fraction of <40%. Documentation of an ejection fraction is not required if not already available.
3. Documentation of the following findings will support eligibility for hospice care:
 - a. Treatment of resistant symptomatic supraventricular or ventricular arrhythmias
 - b. History of cardiac arrest or resuscitation
 - c. History of unexplained syncope
 - d. Brain embolism of cardiac origin
 - e. Concomitant human immunodeficiency virus (HIV) disease
 - f. Documentation of ejection fraction – 40% or less

Appropriate ICD codes for heart disease diagnoses that may meet medical necessity for hospice services are included in *Hospice Services Codes*, accessible from the [Code Sets](#) page at [in.gov/medicaid/providers](https://www.in.gov/medicaid/providers).

Pulmonary Disease

For hospice services to be considered medically necessary for members with pulmonary disease, the member must have current findings from numbers 1–5 in the following list. Findings from numbers 6–9 primarily support documentation for medical necessity.

1. Severe chronic lung disease as documented by both a and b:
 - a. Disabling dyspnea at rest, poor response or unresponsive to bronchodilators, which results in decreased functional capacity, such as bed-to-chair existence, fatigue, and cough
 - b. Prior visits to the emergency department or hospitalizations, which have increased over time, for pulmonary infections or respiratory failure indicating end-stage pulmonary disease
2. Progression of end-stage pulmonary disease as evidenced by the following:
 - a. Prior increasing visits to the emergency department
 - b. Prior hospitalizations for pulmonary infections
 - c. Respiratory failure (documentation of FEV1 [forced expiratory volume after 1 second] < 30% is objective evidence for disease progression that may not be necessary to obtain)
3. Swelling to the lower extremities, which may be indicative of cor pulmonale or right-sided heart failure secondary to pulmonary disease; for example, not secondary to left heart disease or valvulopathy
4. Hypoxemia
5. Long-term oxygen therapy
6. Unintentional progressive weight loss of greater than 10% of body weight over the preceding 6 months
7. Resting tachycardia >100/min.
8. Previous use of ventilator during hospital admission
9. Pulmonary hypertension

There is no ICD diagnosis code specific to end-stage pulmonary disease. Diagnoses for pulmonary disease, which leads to end-stage pulmonary disease, will be covered with appropriate documentation that supports medical necessity.

Appropriate ICD codes for pulmonary disease diagnoses that may meet medical necessity for hospice services are included in *Hospice Services Codes*, accessible from the [Code Sets](https://www.in.gov/medicaid/providers) page at [in.gov/medicaid/providers](https://www.in.gov/medicaid/providers).

Human Immunodeficiency Virus (HIV)/Acquired Immunodeficiency Syndrome (AIDS)

For hospice services to be considered medically necessary for members with human immunodeficiency virus (HIV)/acquired immunodeficiency syndrome (AIDS), the member must have current findings from numbers 1 and 2 in the following list; findings from number 3 primarily support documentation for medical necessity:

1. CD4+ count less than or equal to 200 cells/mm³ or persistent viral load > 100,000 copies/ml, plus one of the following findings:
 - a. CNS lymphoma
 - b. Wasting (loss of 33% of lean body mass), untreated or not responsive to treatment
 - c. Mycobacterium avium complex bacteremia, untreated, unresponsive to treatment, or treatment refused
 - d. Progressive multifocal leukoencephalopathy
 - e. Systemic lymphoma with advanced HIV disease and partial response to chemotherapy
 - f. Visceral Kaposi's sarcoma, unresponsive to therapy
 - g. Renal failure in the absence of dialysis

- h. Cryptosporidium infection
- i. Toxoplasmosis, unresponsive to therapy
- 2. Decreased performance status, as measured by the Karnofsky Performance Status Scale, of < 50%
- 3. Documentation of the following findings will support eligibility for hospice care:
 - a. Chronic persistent diarrhea for 1 year
 - b. Persistent serum albumin < 2.5 gm/dl
 - c. Age > 50 years old
 - d. Absence of antiretroviral, chemotherapeutic, and prophylactic drug therapy related specifically to HIV disease
 - e. Toxoplasmosis
 - f. Congestive heart failure, symptomatic at rest
 - g. Advanced AIDS dementia complex
 - h. Concomitant, active substance abuse

The only appropriate ICD diagnosis code for HIV that meets medical necessity for hospice services is included in *Hospice Services Codes*, accessible from the [Code Sets](#) page at in.gov/medicaid/providers. No other HIV-related diagnosis will be covered. (Examples of HIV diagnosis codes that are noncovered for hospice are also presented in the *Hospice Services Codes*.)

Liver Disease

For hospice services to be considered medically necessary for members with liver disease, the member must have current findings from numbers 1 and 2 in the following list. Findings from number 3 primarily support documentation for medical necessity.

- 1. The member must present with findings from both a and b:
 - a. Prothrombin time prolonged more than 5 seconds over control, or International Normalized Ratio (INR) > 1.5
 - b. Serum albumin < 2.5 gm/dl
- 2. End-stage liver disease is present, and the patient shows at least one of the following:
 - a. Ascites, refractory to treatment or patient noncompliant
 - b. Spontaneous bacterial peritonitis
 - c. Hepatorenal syndrome (elevated creatinine and BUN with oliguria (< 400 ml/day) and urine sodium concentration < 10 meq/l)
 - d. Hepatic encephalopathy, refractory to treatment, or patient noncompliant
 - e. Recurrent variceal bleeding, despite intensive therapy
- 3. Documentation of the following findings will support eligibility for hospice care:
 - a. Progressive malnutrition
 - b. Muscle wasting with reduced strength and endurance
 - c. Continued active alcoholism (> 80 gm ethanol/day)
 - d. Hepatocellular carcinoma
 - e. Hepatitis B surface antigen (HBsAg) positive
 - f. Hepatitis C refractory to interferon treatment

Members awaiting a liver transplant who otherwise fit the hospice criteria may receive hospice benefits. However, if a donor organ is procured, the member must be discharged from hospice services.

Appropriate ICD codes for liver disease diagnoses that meet medical necessity for hospice services are included in *Hospice Services Codes*, accessible from the [Code Sets](#) page at in.gov/medicaid/providers.

Renal Disease

The criteria in this section serve as a guideline to assist in determining medical necessity of hospice services for persons with renal disease (acute renal failure or chronic renal failure).

Members with **acute renal failure** must have current findings from numbers 1 and 2 in the following list. Findings from number 3 primarily support documentation for medical necessity.

1. Creatinine clearance < 10 cc/min (< 15 cc/min for diabetics)
2. Serum creatinine > 8.0 mg/dl (> 6.0 mg/dl for diabetics)
3. Comorbid conditions
 - a. Mechanical ventilation
 - b. Malignancy (other organ system)
 - c. Intractable hyperkalemia (> 7.0) not responsive to treatment
 - d. Uremic pericarditis
 - e. Hepatorenal syndrome
 - f. Intractable fluid overload, not responsive to treatment
 - g. Immunosuppression/AIDS
 - h. Albumin < 3.5 gm/dl
 - i. Cachexia
 - j. Platelet count < 25,000
 - k. Disseminated intravascular coagulation
 - l. Gastrointestinal bleeding
 - m. Chronic lung disease
 - n. Advanced cardiac disease
 - o. Advanced liver disease
 - p. Sepsis

Members with **chronic renal failure** must have current findings from numbers 1 and 2 in the following list. Findings from number 3 primarily support documentation for medical necessity.

1. Creatinine clearance < 10 cc/min (< 15 cc/min for diabetics)
2. Serum creatinine > 8.0 mg/dl (> 6.0 mg/dl for diabetics)
3. Signs and symptoms of renal failure
 - a. Uremia
 - b. Oliguria (< 400 cc/day)
 - c. Intractable hyperkalemia (> 7.0) not responsive to treatment
 - d. Uremic pericarditis
 - e. Hepatorenal syndrome
 - f. Intractable fluid overload, not responsive to treatment

Appropriate ICD codes for kidney disease diagnoses that meet medical necessity for hospice services are included in *Hospice Services Codes*, accessible from the [Code Sets](#) page at in.gov/medicaid/providers.

Stroke and Coma

Appropriate ICD codes for stroke and coma diagnoses that meet medical necessity for hospice services are included in *Hospice Services Codes*, accessible from the [Code Sets](#) page at in.gov/medicaid/providers.

Stroke

The following medical criteria support a terminal prognosis for members with a diagnosis of stroke. Medical criteria are indicators of functional and nutritional status supporting medical necessity for hospice services.

- Palliative Performance Scale (PPS) of 40% or lower
- Inability to maintain hydration and caloric intake with one of the following:
 - Weight loss > 10% during previous 6 months
 - Weight loss > 7.5% in previous 3 months
 - Serum albumin > 2.5 gm/dl
 - Current history of pulmonary aspiration without effective response to intervention by a speech/language therapist
 - Calorie counts documenting inadequate caloric and fluid intake
- Determination of the inability to improve by a neurologist, neurosurgeon, internal medicine specialist, or family practitioner, along with a review by a physical therapist or occupational therapist

If a member does not meet the medical criteria, documentation must describe a relevant comorbidity and rapid decline of functional abilities. For example, a stroke patient with a comorbidity (such as Alzheimer's, Parkinson's disease, adult failure to thrive syndrome, or ALS) may not be able to regain functionality.

Coma

A terminal prognosis for members with a diagnosis of coma may be supported when any three of the following conditions are met on day 3 of a coma:

- Abnormal brain stem response
- Absent verbal response
- Absent withdrawal response to pain
- Serum creatinine > 1.5 mg/dl

Medical criteria is based on a neurological evaluation, which may include electroencephalography (EEG), magnetic resonance imaging (MRI), or computed axial tomography (CT scan).

Adult Failure to Thrive Syndrome

The following information is for general diagnosis and consideration of medical necessity of hospice services for adult failure to thrive syndrome:

- The adult failure to thrive syndrome is characterized by unexplained weight loss, malnutrition, and disability.
- This syndrome has been associated with multiple primary conditions (for example, infections and malignancies), but always includes two defining conditions: malnutrition and disability.
- The syndrome may be an irreversible progression in the member's malnutrition or worsening of disability despite therapy (that is, failure of treatment intended to affect the primary condition responsible for the patient's clinical presentation).
- Comorbid conditions may increase the progression of this syndrome and thus should be identified and addressed.

The following medical criteria would support a terminal prognosis of adult failure to thrive syndrome:

- Nutritional impairment should be significant enough to have an impact on the member's weight.
 - Member's body mass index (BMI) is below 22kg/m².
 - Member is either refusing enteral/parenteral nutritional support or has not responded to such nutritional support, despite an adequate caloric intake.
- Disability associated with adult failure to thrive should be such that the member is significantly disabled, which would be demonstrated by a Karnofsky or Palliative Performance Scale value less than or equal to 40%.

Both BMI and the level of disability of the member should be determined using measurements and observations made within 6 months (180 days) of the most recent certification/recertification date. If enteral nutritional support has been instituted prior to consideration for hospice and will be continued, the BMI and levels of disability should be determined using measurements and observations at the time of the initial certification and at each subsequent recertification for hospice. At the time of recertification, recumbent measurements such as mid-arm muscle area in cm² may be used instead of BMI measurement, so long as there is documentation proving the necessity of such replacement in the member's file.

In the event a member with nutritional impairment does not meet the preceding criteria of refusing enteral/parenteral nutritional support or has not responded to nutritional support, but is still considered eligible for hospice care, he or she may have an alternative diagnosis that adequately describes the clinical circumstances of the member (for example, ICD diagnoses of R63.4 – *Abnormal loss of weight* and R64 – *Cachexia*).

Documentation requirements for hospice admission of members with adult failure to thrive syndrome are as follows:

- Documentation supporting the medical necessity should be legible, maintained in the member's medical records, and available for review upon request.
- Documentation certifying terminal status must contain sufficient information to confirm that the status is based on the criteria of medical necessity.
- Measurement of BMI and functional status of the member using the Karnofsky scale must be documented every 180 days for recertification of hospice benefits.

Appropriate ICD codes for diagnoses that meet medical necessity for hospice are included in *Hospice Services Codes*, accessible from the [Code Sets](#) page at in.gov/medicaid/providers.

Section 6: Billing and Reimbursement

Reimbursement for the Indiana Health Coverage Programs (IHCP) hospice benefit follows the methodology and amounts established by the Centers for Medicare & Medicaid Services (CMS) for administration of the federal Medicare program. Services are reimbursed at one of five all-inclusive per diem rates (based on level of care) for each day in which a member is in hospice:

- Routine home hospice care (days 1-60)
- Routine home hospice care (days 61+)
- Continuous home hospice care
- Inpatient respite hospice care
- General inpatient hospice care

Note: The IHCP announces hospice rates annually. Providers can go to the [Bulletins](#) page at in.gov/medicaid/providers to view bulletins. Search by keywords "hospice" for the most current publication containing hospice rates.

IHCP hospice reimbursement rates are based on Medicare reimbursement rates and methodologies, adjusted to disregard offsets attributable to Medicare premium amounts. The rates are further adjusted for regional differences in wages, using indices published by the CMS. An additional room-and-board per diem is available for routine home hospice care and continuous home hospice care delivered in a nursing facility.

Hospice providers follow the general directions for completing the *UB-04* claim form or electronic equivalent (see the [Claim Submission and Processing](#) module for details), and use the hospice-specific billing information in this module.

Submit fee-for-service (FFS) hospice claims to DXC electronically, using the IHCP Provider Healthcare Portal (Portal) or 837 transaction, or mail paper claim forms to the following address for processing:

DXC Hospice Claims
P.O. Box 7271
Indianapolis, IN 46207-7271

Billing and Reimbursement for Concurrent Hospice and Curative Care for Children

IHCP-enrolled children 20 years of age and under who elect the IHCP hospice benefit may also receive curative care services for the terminal condition concurrent with hospice care. Curative services must be medically necessary and included as part of the hospice plan of care.

PA is required for curative care services only if the IHCP-covered service requires PA. The IHCP provider rendering the curative care services for the terminal condition is responsible for obtaining PA. Curative care services must be included with the hospice plan of care and submitted to the PA contractor to ensure a comprehensive review.

For concurrent hospice and curative care for children, providers bill hospice services as described in this section. The IHCP reimburses curative care services separately from hospice services. Providers must bill using the appropriate diagnosis codes, procedure codes, and claim type.

Method of Calculation

The total hospice per diem amounts reimbursed to a hospice provider are calculated according to the member's *level of care (LOC)* **and** the member's *location of care* as listed:

- Routine home hospice care in the member's home (any residential setting other than a nursing facility) – IHCP hospice per diem only
- Routine home hospice care in a nursing facility – IHCP hospice per diem plus room and board per diem
- Continuous home hospice care in the member's home (any residential setting other than a nursing facility) – IHCP hospice per diem only
- Continuous home hospice care in a nursing facility – IHCP hospice per diem plus room and board per diem
- Inpatient respite hospice care for members who reside in a private home – IHCP hospice per diem only (*Note: There is no additional room and board per diem for this service.*)
- General inpatient hospice care regardless of the member's place of residence – IHCP hospice per diem only (*Note: There is no additional room and board per diem for this service.*)

These reimbursement rules are listed in Tables 7 and 8.

Table 7 – Hospice Reimbursement for Members Receiving Services at Home

Level of Care	Private Home, Assisted Living, ICF/IID	
	Hospice Per Diem	Room and Board
Routine home	Yes	No
Continuous home	Yes	No
Inpatient respite	Yes	No
General inpatient	Yes	No

Table 8 – Hospice Reimbursement for Members Residing in a Nursing Facility

Level of Care	Nursing Facility	
	Hospice Per Diem	Room and Board
Routine home	Yes	Yes
Continuous home	Yes	Yes
Inpatient respite	No	No
General inpatient	Yes	No

Routine Home Hospice Care

Medicare hospice rule *CMS 1629-F* establishes two rates for routine home hospice care:

- A higher per diem rate applies to routine home hospice care rendered during the first 60 days of care
- A reduced per diem rate applies to routine home hospice care rendered on days thereafter.

If a patient has a live discharge from hospice and then is readmitted within 60 days, the 0–60 and 61+ day count will continue from the previous date of discharge. If the patient has a live discharge from hospice and then is readmitted at day 61 or later, the count will start over.

See the following examples of reimbursement at the new rates:

Example 1:

A member is in hospice for 58 days and then discharged. The member is then readmitted to hospice 7 days later. Upon readmission, the count of patient hospice days will begin at day 59. Routine home hospice care services rendered on days 59–60 will be paid at the higher rate; routine home hospice care services on days 61 and after will be paid at the lower rate.

Example 2:

A member is in hospice for 45 days and is then discharged. The member is then readmitted to hospice 65 days after discharge. Upon readmission, the count of hospice patient days will begin at day 1. Routine home hospice care services rendered on days 1–60 will be paid at the higher rate; routine home hospice care services on days 61 and after will be paid at the lower rate.

Medicare hospice rule *CMS 1629-F* also establishes an SIA payment for face-to-face services provided by a registered nurse (RN) or social worker during the last 7 days of a member's life. See the [Billing Services Associated with the SIA Payment](#) section.

Delivered in the Member's Home

The IHCP reimburses the hospice provider at the routine home care rate for each day the member is at home (any residential setting other than a nursing facility), under the care of the hospice provider, and not receiving continuous home hospice care. This rate is paid without regard to the volume or intensity of routine home hospice care services on any given day.

Delivered in a Nursing Facility

The IHCP reimburses the hospice provider at the routine home care rate for each day the member is in a nursing facility, under the care of the hospice provider, and not receiving continuous home hospice care. This rate is paid without regard to the volume or intensity of routine hospice home care services on any given day. In addition, the hospice provider is paid an additional room and board per diem at 95% of the lowest nursing facility rate to cover costs incurred by the contracted nursing facility. The additional room and board per diem is 95% of the single nursing facility case-mix rate.

Continuous Home Hospice Care

Continuous home hospice care is provided only during a period of crisis. A period of crisis occurs when a patient requires continuous care, primarily nursing care, to achieve palliation and management of acute medical symptoms. A minimum of 8 hours of care must be provided during a 24-hour day that begins and ends at midnight. A registered nurse or a licensed practical nurse must provide care for more than half the total period of care. This care need not be continuous and uninterrupted. If less skilled care is needed on a continuous basis to enable the member to remain at home, this service is covered as routine home hospice care.

Delivered in a Member's Home

The continuous home care rate is divided by 24 hours to arrive at an hourly rate. For every hour or part of an hour of continuous care furnished in the home (any residential setting other than a nursing facility), the hourly rate is reimbursed to the hospice provider for up to 24 hours a day.

Delivered in a Nursing Facility

The continuous home care rate for services delivered in a nursing facility is divided by 24 hours to arrive at an hourly rate. For every hour or part of an hour of continuous care furnished, the hourly rate is reimbursed to the hospice provider up to 24 hours a day. In addition, the hospice provider is paid an additional room and board per diem at 95% of the lowest nursing facility rate to cover costs incurred by the contracted nursing facility. The additional room and board per diem is 95% of the single nursing facility case-mix rate.

Inpatient Respite Hospice Care

The IHCP reimburses the hospice provider at the inpatient respite care rate for each day the member is in an approved inpatient facility and is receiving respite care. Respite care is short-term inpatient care provided to the member only when necessary to relieve family members or others caring for the member. Respite care can be provided only on an occasional basis. Payment for respite care can be made for a maximum of 5 consecutive days at a time, including the date of admission, but not counting the date of discharge. Payment for the sixth and any subsequent days is made at the routine home care rate.

For inpatient respite stays, the day of discharge is not paid unless it is the date of death. This service applies only to members who normally reside in **private** homes.

General Inpatient Hospice Care

The IHCP reimburses the hospice provider at the general inpatient hospice care rate for each day the member is in an approved inpatient hospice facility and is receiving general inpatient hospice care for pain control or acute or chronic symptom management related to the terminal illness that cannot be managed in other settings. The hospice provider is the professional manager of the patient's care, regardless of the physical setting of that care or level of care. If the inpatient facility is not also the hospice provider, the hospice provider must have a contract with the inpatient facility delineating the roles of each provider in the plan of care.

For general inpatient stays, the day of discharge is not paid unless it is the date of death.

Note: Total inpatient days (general inpatient days and inpatient respite care days) for an individual hospice provider and any contracted agents may not exceed 20% of all days provided to all IHCP hospice members serviced by that specific provider during the 12-month period beginning November 1 of each year and ending October 31 of the next year. See the [Limitation of Payments for Inpatient Care](#) section for the additional information regarding this limitation.

Billing Services Associated with the SIA Payment

The service intensity add-on (SIA) payment is in addition to the routine home care per diem rate in both the member's home and in the nursing facility. The SIA payment is made for services provided by an RN or social worker during the last 7 days of a member's life. The SIA payment amount is calculated using the continuous home care hourly rate adjusted by the regional wage index. The SIA payment is limited to 16 units or 4 hours per day. The SIA payment is applied *only* to routine home hospice care LOC.

These billing instructions should be followed:

- The following revenue codes must be billed for the SIA payment as appropriate:
 - 551 for RN service intensity add-on payment
 - 561 for social worker service intensity add-on payment
- The SIA revenue codes must be billed as detail line items on the claim when billing for routine home hospice care services for the same dates of service.
- A procedure code is not required in conjunction with revenue codes 551 and 561.
- Claims with revenue codes 551 or 561 must include occurrence code 55 and the date of death in the first open occurrence code field.
- The claim must include a patient status discharge code of 20, 40, 41, or 42 (field 17 of the UB-04 claim form).

The units billed for revenue codes 551 and 561 must reflect the time spent with the member in 15-minute increments, with no rounding up. The entire 15 minutes must be used rendering services to the member and must be documented in the medical record.

The following examples show how to bill for the SIA payment.

Example 1:

RN spends 30 minutes with the member; revenue code 551 is billed for a total of two units.

Example 2:

Social worker spends 40 minutes with the member; revenue code 561 is billed for a total of two units (rounded to the nearest 15-minute increment without rounding up).

Payment for Nursing Facility Residents

The routine and continuous care hospice reimbursement methodologies make a distinction between care provided in a **home** setting versus a **nursing facility** because hospice residents in an IHCP-certified nursing facility require an additional room and board per diem, which is paid directly to the hospice provider. The IHCP pays 95% of the nursing facility's per diem for those dates of service on which the member was a resident. The hospice provider is responsible for paying the nursing facility according to their contract. The contract must be in compliance with federal and state regulations.

Myers and Stauffer LC, is the long-term care (LTC) rate-setting contractor and sets the IHCP rates for nursing facilities, hospices, home health agencies, and group homes. Hospice providers can obtain current rate information for a particular nursing facility from the Myers and Stauffer's LTC website as follows:

1. Go to the [Myers and Stauffer website](https://in.mslc.com/Indiana) at in.mslc.com/Indiana.
2. Click **Long-Term Care**, located on the left, to go to the *Long-Term Care* page.
3. Click the **Nursing Facility** folder.
4. Click the **Other Reports** folder.
5. Click **Cumulative Rate Listing** to open a report listing Medicaid rates for all Medicaid-certified nursing facilities.

Medicaid rates are updated within 24 hours of the finalization.

Room and Board

In the context of the hospice benefit **only**, the term *room and board* includes personal care services not otherwise provided by the hospice and all assistance in the activities of daily living and socializing activities, administration of medication, maintaining the cleanliness of a resident's room, and supervision and assistance in the use of durable medical equipment (DME) and prescribed therapies, as stated in *Indiana Administrative Code 405 IAC 1-16-4*. The room-and-board rate is 95% of the NF case-mix rate paid to the NF for the dates of service the member was a resident of that facility. When an NF resident elects hospice, whether it is Medicare or Medicaid, direct IHCP payment to the NF for the resident must be discontinued as the hospice provider is responsible for coordinating all the hospice care. The NF may no longer bill the IHCP directly for room-and-board services after the NF resident elects the Medicare or Medicaid hospice benefit.

To ensure compliance with *405 IAC 1-16-4*, IHCP-enrolled hospice providers and IHCP-enrolled NFs must comply with the following guidelines. Failure to comply with these procedures results in recoupment of funds.

- The NF and the hospice provider must first have a written agreement (contract) stating the hospice provider takes full responsibility for the professional management of the individual's hospice care. This contract must also specify the NF agrees to provide room-and-board services as described in *42 USC 1396d(o)(3)*. **Hospice services cannot be provided until both parties have finalized a contract.**
- The NF resident must elect hospice by signing the *Medicaid Hospice Election* form (*State Form 48737 [R2/1-12]*). The resident can designate an effective date for the election that is later than the date the election form is signed. The effective date of the election form is the date hospice services begin and payment by IHCP to the NF must stop.
- Hospice providers must properly complete and send the election form, the physician certification form, and the plan of care as required by *405 IAC 5-34-5*, *405 IAC 5-34-6*, and *405 IAC 5-24-7* for the Medicaid-only hospice member. All three forms must be submitted to the Hospice Authorization Unit within 10 days of the effective date of the election.
- Hospice providers must properly complete the *Hospice Authorization Notice for Dually Eligible Medicare/Medicaid Nursing Facility Residents* form (*State Form 51098 [3-03]/OMPP 0014*) and attach a copy of the hospice agency's election form, which reflects the date of hospice election and the signature of the member or the member's representative. The form and the hospice agency's election form must be submitted to the Hospice Authorization Unit within 10 days of the effective date of the election.
- Failure to comply with these paperwork submission procedures is a violation of State and federal regulations because hospice providers are required to notify state Medicaid agencies when a dually eligible hospice member elects, revokes, or changes hospice providers under both programs. Hospice providers are also reminded that the terms of the *IHCP Provider Agreement* that the hospice agency signed include but are not limited to the following:
 - To abide by and comply with all federal and State statutes and regulations pertaining to the IHCP because they are amended from time to time
 - To abide by the *IHCP Provider Reference Modules* when amended as well as all provider bulletins and notices. Any amendments to the *IHCP Provider Reference Modules* and all provider bulletins and notices are communicated to the provider and are binding upon receipt. Amendments, provider bulletins, and notices are posted to in.gov/medicaid/providers.

Case-mix rates are adjusted four times each calendar year in January, April, July, and October. The Office of Inspector General (OIG) has advised the IHCP that the hospice provider and the NF can negotiate payment of anywhere between 95% and 100% of the NF's IHCP daily rate for room-and-board services in their contract. This capability allows the rates to be negotiated without concern about fraud or kickbacks.

Decertification of a Nursing Facility and Payment of Room and Board

When the Indiana State Department of Health (ISDH) decertifies a facility, the notification letter sent to the NF specifies the effective date the IHCP reimbursement for NF care (including hospice room and board) must cease. *CoreMMIS* is updated to reflect the stop payment date. IHCP payment for hospice revenue codes 650, 658, and 659 must also cease.

IHCP payment for any hospice services provided in an NF is subject to the NF being certified by the IHCP. For example, if an NF is decertified for the entire month of October, the effect on hospice reimbursement is as follows:

- Hospice revenue codes 650 and 658 – Hospice per diem plus NF room and board for Medicaid-only hospice members is not reimbursed for the month of October.
- Hospice revenue code 659 – Room and board only for dually eligible (Medicare and Medicaid) NF hospice member is not reimbursed for the month of October.

The NF is sent a notification letter indicating the effective date the IHCP reimbursement ceases. Upon completion of the follow-up survey by the ISDH, the NF is sent a notification letter with the findings. If the ISDH has recertified the facility for IHCP reimbursement, the notification letter indicates the start date the IHCP reimbursement may resume.

While the hospice provider is not copied on the ISDH letters, the hospice does have the following mechanisms to ensure notification of an NF decertification:

- The hospice's contract with the NF can address notification procedures the nursing facility must follow to inform the hospice regarding any change in certification, which affects IHCP reimbursement and any involvement in the transfer or discharge of the resident to another certified NF.
- The patient is also notified by the local Division of Family Resources (DFR) office regarding the NF's decertification.

When an NF is decertified, the local ombudsman is also notified. The local ombudsman is involved in working with the family and the NF for the discharge or transfer of the resident to another facility.

Hospice providers can check the [ISDH website](http://state.in.us/isdh) at state.in.us/isdh to determine if an NF has been decertified.

Payment for Date of Discharge

The Family and Social Services Administration (FSSA) pays 95% of the NF per diem rate for the hospice member's day of admission to the NF. The FSSA does not pay the NF per diem or NF room-and-board services for the day a hospice member is discharged from the NF.

When a hospice member dies in an NF, the hospice member's date of death follows the same reimbursement procedures as the date of physical discharge from the NF. Hospice claims that include a member's date of death require using patient status discharge code 20, 40, 41, or 42. Providers are required to report occurrence code 55 for members discharged as deceased. **If a hospice member is admitted to the NF and dies on the day of admission, the NF is not paid for room-and-board services for that day.** These reimbursement procedures for hospice members residing in nursing facilities are consistent with current IHCP reimbursement for NF covered services.

Hospice providers are reimbursed the hospice per diem according to the hospice member's level of care on the day of the hospice member's admission to the NF and the day the hospice member is physically discharged from the NF. The reimbursement procedures for hospice providers are consistent with current Medicare and IHCP guidelines for the Medicare and the IHCP hospice benefit.

The following IHCP reimbursement procedures apply to hospice providers and NF providers when the hospice provider discharges the hospice member from hospice care or the hospice member revokes hospice care, but the IHCP member physically remains in the NF:

- The hospice provider must still bill the IHCP for NF room-and-board services and the hospice per diem for the date of hospice discharge or the date of hospice revocation because the hospice member is still under hospice care on those dates of service.
- The NF can resume billing the IHCP directly for NF care on the day after hospice discharge or hospice revocation because the IHCP member has resumed NF care on that date.

It is appropriate for transition-related Home and Community-Based Services (HCBS) waiver services to be provided on the same day as long-term care client discharges. Provision of certain HCBS waiver services to clients with hospice level of care may also be appropriate. Payment for services provided under either of these circumstances will be systematically denied unless specially handled. Providers submitting claims for waiver services on the client's date of discharge from the long-term care facility or during a period of hospice level of care should contact their Provider Relations field consultant for special claim handling. Providers that have had claims previously denied for these reasons should also contact their field consultant for special handling.

Patient Liability for a Hospice Member Residing in a Nursing Facility

An IHCP member (whether Medicaid-only or dually eligible for Medicare and Medicaid) residing in an NF is responsible for the member's portion of the payment prior to the IHCP reimbursing the remaining balance of NF care (this includes room-and-board services when the individual elects the Medicare and Medicaid hospice benefits). Patient liability includes, but is not limited to, an individual's personal savings account, Medicare pension funds, and Social Security checks. A member's patient liability is deducted starting the first date of service the individual is residing in an NF and is eligible for the IHCP NF LOC.

When a hospice provider submits hospice claims for NF room-and-board services for a dually eligible (Medicare and Medicaid) or Medicaid-only hospice member, *CoreMMIS* deducts the patient liability portion from the claim and the remaining balance reflects the room-and-board payment. The total patient liability is not reflected on the Remittance Advice (RA) because the hospice claim is paid as a *UB-04* claim with home health edits.

Hospice providers can obtain a member's patient liability for a particular month by contacting Customer Assistance toll-free at 1-800-457-4584, or using one of the Eligibility Verification System (EVS) options.

When a provider obtains the patient liability amount, the RA is used to determine how DXC calculates the paid amount. The following formula is used if the RA does not match the rates the provider originally submitted on the claims:

- Step 1: NF case-mix rate on file \times 95% (0.95) = allowed amount on the RA for room and board
- Step 2: (Number of dates of service \times allowed amount on RA) – patient liability = room-and-board amount

IHCP Reimbursement Policy

This section clarifies the IHCP reimbursement policy and process for billing Medicaid hospice claims when a member has private insurance, Medicare hospice, and Medicaid room and board; and the process for billing Medicaid hospice claims when the member has private insurance and Medicaid.

It is not mandatory for NF providers to reserve beds; however, the FSSA continues to reimburse hospice providers at one-half the NF case-mix reimbursement rate for reserving NF beds for hospice members, when the occupancy criteria are met as set forth in *405 IAC 5-34-12*.

It is the hospice agency's responsibility to confirm the NF occupancy percentage on the date that the leave of absence begins. Hospice providers can bill the IHCP for leave days only when the NF occupancy percentage is at 90% or greater on the day the leave begins. If the NF occupancy percentage falls below 90% following the date the leave began, the hospice provider can continue to bill the 50% of the NF's case-mix reimbursement rate for the entire hospital or therapeutic leave.

When the NF occupancy is below 90% on the date the leave of absence begins, the hospice agency should use revenue code 180 to bill the IHCP for leave days. Revenue code 180 is a nonpaid revenue code used to generate an IHCP denial, and it can be used when charging a resident or legal guardian for nonreimbursed bed-hold days.

The explanation of benefits (EOB) detail for revenue code 180 lists the claim as denied, with EOB 4215 – *Leave days not a covered service for this bill type – nursing facility occupancy less than 90%*. A member who receives hospice services and resides in a nursing facility has dual eligibility, the hospice provider must bill claims to the IHCP using revenue code 659 (room and board for dually eligible NF hospice members only). A member is considered dually eligible if he or she is enrolled in both Medicare and Medicaid. The member may also have other commercial insurance.

When verifying member eligibility, members who are dually eligible will be listed as having both Qualified Medicare Beneficiary coverage and also Full Medicaid or Package A – Standard Plan coverage. These members are referred to as QMB-Also.

When an IHCP member who receives hospice services and resides in a nursing facility is not dually eligible (not a QMB), the hospice provider must bill claims to the IHCP using revenue code 650 (for routine home hospice care delivered in a nursing facility) or 658 (for continuous home hospice care delivered in a nursing facility). The provider must use revenue code 650 or 658 even if the member has other commercial insurance and Medicaid.

If other insurance pays for the hospice care services in full, the hospice provider shall only receive payment from the IHCP for room-and-board services.

To refund the overpayment, the provider must complete a *Hospice Accounts Receivable Refund Adjustment* form. The form is located on the [Forms](#) page at in.gov/medicaid/providers. Mail the completed form and a check for the overpayment amount to DXC at the following address:

DXC Refunds
P.O. Box 2303 Dept. 130
Indianapolis, IN 46206-2303

Note: CoreMMIS automatically deducts the patient liability when third-party liability payment is received.

Revenue Codes

As indicated in [Table 7](#) and [Table 8](#), the IHCP reimbursement for hospice services is made at one of four all-inclusive per diem rates, or levels of care, and one of two location types, for each day an IHCP member is under the care of the hospice provider.

Hospice providers complete the *UB-04* claim form and identify hospice service delivery according to one of the following revenue codes:

- Revenue code 183 for nursing facility bed hold for hospice therapeutic leave days
- Revenue code 185 for nursing facility bed-hold for hospitalization for services unrelated to the terminal illness of the hospice member
- Revenue code 551 for RN service intensity add-on payment
- Revenue code 561 for social worker service intensity add-on payment
- Revenue code 650 for routine home hospice care delivered in a nursing facility
- Revenue code 651 for routine home hospice care delivered in the home
- Revenue code 652 for continuous home hospice care delivered in the home

Note: For revenue codes 651 and 652, “in the home” means any residential environment other than a nursing facility. These codes are applicable for services delivered in a private home, an ICF/IID, or any other non-NF setting where the member resides.

- Revenue code 655 for inpatient respite hospice care
- Revenue code 656 for general inpatient hospice care

Note: Inpatient facility is defined as a hospital, long-term care facility, or the facility of a hospice provider that provides care 24 hours a day as outlined in Code of Federal Regulations 42 CFR 418.110.

- Revenue code 657 for hospice direct-care physician services
- Revenue code 658 for continuous home hospice care delivered in a nursing facility
- Revenue code 659 for room and board for dually eligible NF hospice members only

Hospice revenue codes, along with the descriptions to be used when billing hospice services, are included in *Hospice Services Codes*, accessible from the [Code Sets](#) page at in.gov/medicaid/providers.

Hospice providers must bill only one hospice-related revenue code per day. However, revenue codes 183, 185, 551, 561, and 657 can be billed on the same day as other hospice revenue codes. A detailed description of each revenue code is provided as follows:

- Revenue code 183 for nursing facility bed hold for hospice therapeutic leave days
 - The hospice provider receives 50% of the 95% NF case-mix rate for the room-and-board rate associated with therapeutic leave of absence days.
 - A total of 18 therapeutic leave of absence days are allowed per patient per calendar year.
 - Revenue code 183 may be billed on the same day as other hospice revenue codes.
 - One day equals one unit of service.
- Revenue code 185 for nursing facility bed-hold for hospitalization for services unrelated to the terminal illness of the hospice member
 - The hospice provider receives 50% of the 95% NF case-mix rate associated with each hospitalization up to 15 days per occurrence.
 - Revenue code 185 may be billed on the same day as other hospice revenue codes.
 - One day equals one unit of service.
- Revenue code 551 for RN service intensity add-on payment
 - Must be billed with routine home hospice care revenue codes 650 or 651 on the same claim and same date of service.
 - The sum of revenue code 551 and/or 561 is limited to 16 units or 4 hours a day.
 - A procedure code is not required.
 - Claims must include occurrence code 55 and the date of death in the first open occurrence code field.
 - Claims must include the appropriate patient status code:
 - Patient status code 20 – Expired
 - Patient status code 40 – Expired at home
 - Patient status code 41 – Expired in a medical facility, such as a hospital, skilled nursing facility (SNF), intermediate care facility (ICF), or freestanding hospice
 - Patient status code 42 – Expired – place unknown

- Revenue code 561 for social worker service intensity add-on payment
 - Must be billed with routine home hospice care revenue codes 650 or 651 on the same claim and same date of service.
 - The sum of revenue code 551 and/or 561 is limited to 16 units or 4 hours a day.
 - A procedure code is not required.
 - Claims must include occurrence code 55 and the date of death in the first open occurrence code field.
 - Claims must include the appropriate patient status code:
 - Patient status code 20 – Expired
 - Patient status code 40 – Expired at home
 - Patient status code 41 – Expired in a medical facility, such as a hospital, SNF, ICF, or freestanding hospice
 - Patient status code 42 – Expired – place unknown
- Revenue code 650 for routine home hospice care delivered in a nursing facility.
 - The IHCP pays the hospice provider at the routine home care rate for each day the member is in an NF under the care of the hospice provider and not receiving continuous home hospice care.
 - The IHCP pays this rate without regard to the volume or intensity of routine home hospice care services on any given day.
 - In addition, the IHCP pays the hospice provider 95% of the lowest NF case-mix rate to cover room-and-board costs incurred by the contracted NF. The provider should bill only normal and customary routine home care amounts as the billed amount; CoreMMIS calculates 95% of the lowest NF rate and pays accordingly.
 - Nursing facility room and board are not billable for the date of death.
 - Providers also cannot bill for NF room and board for the date the member is physically discharged from the NF.
 - Claims must include the appropriate occurrence code and the date of death or discharge in the first open occurrence code field:
 - Occurrence code 42 for members discharged as live
 - Occurrence code 55 for members discharged as deceased
 - One day equals one unit of service.
- Revenue code 651 for routine home hospice care delivered in the home
 - The IHCP pays the hospice at the routine home care rate for each day the member is at home, under the care of the hospice provider, and not receiving continuous home hospice care.
 - The IHCP pays this rate without regard to the volume or intensity of routine home hospice care services on any given day.
 - Claims must include the appropriate occurrence code and the date of death or discharge in the first open occurrence code field:
 - Occurrence code 42 for members discharged as live
 - Occurrence code 55 for members discharged as deceased
 - One day equals one unit of service.

*Note: When a Medicaid-only hospice member is admitted to a nursing facility **for treatment of a nonterminal condition**, the hospice provider must bill for hospice services using revenue codes 650 or 658 while the hospice member is in the facility. When the hospice patient has resumed residence in his or her home, the hospice provider must bill the IHCP using hospice review codes 651 or 652 for those dates of service following the discharge from the facility.*

- Revenue code 652 for continuous home hospice care delivered in a the home
 - The provider gives continuous home hospice care only during a period of crisis.
 - A period of crisis occurs when a patient requires continuous care, primarily nursing care, to achieve palliation and management of acute medical symptoms.
 - The provider must provide a minimum of 8 hours of care during a 24-hour day that begins and ends at midnight.
 - A registered nurse (RN) or licensed practical nurse (LPN) must provide care for more than half the total time. This care need not be continuous and uninterrupted.
 - Less-skilled care needed continuously to enable the member to remain at home is covered as routine home hospice care.
 - Divide the continuous home care per diem rate by 24 hours to calculate an hourly rate. For every hour or part of an hour of continuous care furnished, the IHCP reimburses the hourly rate to the hospice provider, up to 24 hours a day.
 - Claims must include the appropriate occurrence code and the date of death or discharge in the first open occurrence code field:
 - Occurrence code 42 for members discharged as live
 - Occurrence code 55 for members discharged as deceased
 - One hour equals one unit of service.
- Revenue code 655 for inpatient respite hospice care
 - The IHCP pays the hospice provider at the inpatient respite care rate for each day the member is in an approved inpatient facility and is receiving respite care.
 - Respite care is short-term inpatient care provided to the member only when necessary to relieve the family members or other people caring for the member. Respite care may be provided only on an occasional basis.
 - The IHCP pays for respite care for a maximum of 5 consecutive days at a time, including the date of admission but not counting the day of discharge.
 - The IHCP pays for the sixth and any subsequent days at the routine home care rate.
 - This service applies only to members who normally reside in *private* homes.
 - The additional amount for room and board is not available for members receiving respite care.
 - One day equals one unit of service.
 - According to 405 IAC 1-16-2(i), when a member is receiving general inpatient or inpatient respite care, the applicable inpatient rate (general or respite) is paid for the date of admission and all subsequent inpatient days except the day on which the patient is discharged. For the day of discharge, the appropriate home care rate is paid unless the patient dies as an inpatient. In the case where the member is discharged deceased, the applicable inpatient rate (general or respite) is paid for the date of discharge.
- Revenue code 656 for general inpatient hospice care
 - The IHCP pays the hospice provider at the general inpatient hospice rate for each day the member is in an approved inpatient hospice facility and is receiving general inpatient hospice care for pain control, or acute or chronic symptom management, that cannot be managed in other settings.
 - The additional amount for room and board is not available for members receiving respite care.
 - One day equals one unit of service.
 - According to 405 IAC 1-16-2(i), when a member is receiving general inpatient or inpatient respite care, the applicable inpatient rate (general or respite) is paid for the date of admission and all subsequent inpatient days except the day on which the patient is discharged. For the day of discharge, the appropriate home care rate is paid unless the patient dies as an inpatient. In the case where the member is discharged deceased, the applicable inpatient rate (general or respite) is paid for the date of discharge.

- Revenue code 657 for hospice direct care physician services
 - The IHCP reimburses on a fee-for-service basis for physician services provided by a physician who is an employee of the hospice provider or subcontracted by the hospice. The hospice provider bills for these services under the hospice National Provide Identifier (NPI).
 - Providers can bill this revenue code on the same day as other hospice revenue codes.
 - One day equals one unit of service.
- Revenue code 658 for continuous home hospice care delivered in a nursing facility
 - Divide the continuous home care rate by 24 hours to calculate an hourly rate. For every hour or part of an hour of continuous care furnished, the IHCP reimburses the hourly rate to the hospice provider, up to 24 hours a day.
 - All limitations listed for the home setting also apply in the NF setting.
 - In addition, the IHCP pays the hospice provider 95% of the lowest NF case-mix rate to cover room-and-board costs incurred by the contracted NF.
 - Providers cannot bill for NF room and board for the date of death.
 - Providers also cannot bill for NF room and board for the date the member is physically discharged from the NF.
 - Claims must include the appropriate occurrence code and the date of death or discharge in the first open occurrence code field:
 - Occurrence code 42 for members discharged as live
 - Occurrence code 55 for members discharged as deceased
 - One hour equals one unit of service.
- Revenue code 659 for room and board for dually eligible NF hospice members only
 - Use this revenue code for dually eligible members residing in an NF.
 - This code represents the room-and-board portion of the hospice per diem.
 - In addition, the IHCP pays the hospice provider 95% of the lowest NF case-mix rate to cover room-and-board costs incurred by the contracted NF.
 - Revenue code 659 must not be billed with the following hospice-related revenue codes: 650, 651, 652, 655, 656, and 658.
 - Providers cannot bill for NF room and board for the date of death.
 - Providers also cannot bill for NF room and board for the date the member is physically discharged from the nursing facility.
 - One day equals one unit of service.

Limitation of Payments for Inpatient Care

Reimbursement for inpatient days, general and respite, is subject to an overall annual limitation established by the federal Medicare program as described in federal regulations at *42 CFR 418.302(f)* and State regulations at *405 IAC 1-16-3*. Total *inpatient* days (general inpatient days and inpatient respite care days) for an individual hospice provider and any contracted agents may not exceed 20% of **all** days provided to **all** IHCP hospice members *served by that specific provider* during the 12-month period beginning November 1 of each year, and ending October 31 of the next year.

This payment limitation for inpatient services at the end of the inpatient capitation period, October 31, is determined by the following calculation:

1. The maximum number of allowable inpatient days is calculated by multiplying the total number of a provider's IHCP hospice days by 20.
2. If the total number of days of inpatient care to IHCP hospice members is less than or equal to the maximum number of inpatient days computed in step 1, then there is no adjustment.

3. If the total number of days of inpatient care to IHCP hospice members is greater than the maximum number of inpatient days computed in step 1, then the payment limitation is determined by the following calculation:
 - a. Calculate the ratio of maximum allowable inpatient days to the number of actual days of inpatient care, and multiply this ratio by the total reimbursement for inpatient care.
 - b. Multiply excess inpatient care days by the routine home care rate.
 - c. Add together the amounts calculated in 3a and 3b.
 - d. Compare the amount in 3c with total reimbursement to the hospice provider for inpatient care during the cap period. The amount that total reimbursement to the hospice for inpatient care exceeds the amount calculated in 3c is the amount due from the hospice provider.

If it is determined the inpatient rate should not be paid, any days the hospice receives payment at a routine home care rate are not counted as inpatient days.

Completion of Continuation Claim Using *UB-04* Claim Form

The *UB-04* claim form has only 22 lines, so an entire month cannot be billed on one page. However, the hospice provider has the option to prepare a continuation claim. A continuation claim has more than one *UB-04* claim form, but must be completed as if it is one claim for payment by *CoreMMIS*. The hospice provider must complete the continuation claim as follows:

1. Mark the first *UB-04* claim form page 1 of 2 on line 23 of the form.
2. Complete the first 22 lines of the *UB-04* claim form.
3. Do not subtotal the first page of the claim (only the last page of the continuation claim must be totaled or *CoreMMIS* reads the claim as two claims rather than one).
4. Mark the second *UB-04* claim form page 2 of 2 on line 23.
5. Complete the second *UB-04* claim form for remaining dates of service for the month.
6. Provide a grand total for the continuation claim on the *second UB-04* claim form.
7. Rotate the second *UB-04* claim form (end to end) and place under the first *UB-04* claim form. **Do not staple or paperclip.**

If the hospice provider does not want to complete a continuation claim, the hospice provider has the option to complete two separate *UB-04* claim forms. The first claim form has enough space for the hospice provider to bill for the first 22 days of service for the month. The hospice provider totals the daily amounts for a grand total. The hospice provider then completes a second *UB-04* claim form for the remaining days of service for the month, and totals the daily amounts for a grand total.

See the [Claim Submission and Processing](#) module for more information about the IHCP claim process.

Reimbursement for Physician Services

The following sections describe how to bill for physician services under the IHCP hospice benefit.

Physician Services under Revenue Codes 651 through 655

The basic payment rates for IHCP hospice care represent full reimbursement to the hospice provider for covered services related to the treatment of the patient's terminal illness. Covered services include the administrative and general activities performed by physicians who are employees of or working under

arrangements with the hospice provider. The physician who serves as medical director and the physician member of the hospice interdisciplinary group generally performs the following group activities:

- Establishment of governing policies
- Participation in the establishment of plans of care
- Periodic review and update of plans of care
- Supervision of care and services

The costs for these services are included in the reimbursement rates for the following:

- Continuous home hospice care, revenue code 652 or 658
- Inpatient respite hospice care, revenue code 655
- Routine home hospice care, revenue code 650 or 651

Physician Services under Revenue Code 657

Reimbursement for a hospice-employed physician's direct patient services, not rendered by the hospice physician volunteer, is billed as an additional payment by the hospice provider under the hospice provider number. The only physician services billed by a hospice provider are direct patient care services. Laboratory and x-ray services are included in the hospice provider's daily rates.

Consulting physicians are physicians who see the hospice patient for treatment of the terminal illness and are paid for the services out of the hospice per diem. To bill for consulting physician charges, the hospice must do the following:

- Ensure hospice providers have a contract with the consulting physician addressing the contracted service, cost for service, rate paid for service, and acknowledgement the hospice is the professional manager of the patient's hospice care.
- Bill the IHCP using hospice revenue code 657 and track the claim's payment by keeping the IHCP Remittance Advice for this charge along with the consulting physician's bill or invoice for the service rendered.

Hospice providers must meet all standard billing rules and claim filing limits when billing for a consulting physician. If the consulting physician has submitted a bill past the 180-day filing limit, the claim will deny.

Prior-Authorized Physician Services

The IHCP reimburses a physician's direct patient services not rendered by a hospice physician volunteer as an additional payment, in accordance with the usual IHCP reimbursement methodology for physician services. The hospice must not bill these services under the hospice National Provider Identifier (NPI).

An attending physician may bill only the physician's personal professional services. Do not include the costs for services, such as laboratory or x-ray, on the attending physician's billed charges when those services relate to the terminal condition. Include these costs in the daily hospice care rates as they are expressly the responsibility of the hospice provider. Providers may bill independent physician services on the *CMS-1500* claim form or electronic equivalent (837P transaction or Portal professional claim).

Volunteer Physician Services

Volunteer physician services are excluded from IHCP reimbursement. A physician who provides volunteer services to a hospice can be reimbursed for nonvolunteer services provided to hospice patients.

If the volunteer physician is working under a specific arrangement with the hospice to provide nonvolunteer direct patient services, the hospice can be reimbursed on behalf of a volunteer physician for specific nonvolunteer direct patient care services. The hospice must have a liability to reimburse the physician for the services rendered. The hospice provider must bill under the hospice provider number for an additional amount using revenue code 657. The hospice provider must only bill for the physician's direct care services. Laboratory and x-ray services are included in the hospice provider's daily rate.

To determine which services are furnished on a volunteer basis and which are not, a physician must treat IHCP patients on the same basis as other hospice patients. For example, a physician cannot designate all physician services rendered to non-IHCP patients as volunteer and at the same time seek payment for all physician services rendered to IHCP patients.

Emergency Services

If emergency services are related to the terminal illness, and the hospice member has not revoked the hospice benefit, the hospice provider is responsible for hospice and transportation charges associated with all emergency services provided.

If the emergency services are unrelated to the terminal illness, the IHCP pays the transportation and hospital claims associated with the emergency services according to the member's program enrollment.

Treatment for the Hospice Member's Nonterminal Condition

When the IHCP member elects the IHCP hospice benefit, care for the terminal condition comes under the supervision of the IHCP hospice provider. The IHCP covers the IHCP hospice member's medical care for conditions not related to the terminal illness. The IHCP expects the hospice provider to actively interact and coordinate services with other IHCP providers providing nonhospice services.

The IHCP hospice member's medical care for the nonterminal conditions can be met by one of the following methods:

- Outpatient physician services
- Inpatient admission or outpatient hospital services
- Admission to a nursing facility

The hospice provider's coordination and billing responsibilities for each treatment option are described in the following sections. The provider billing for the treatment of the nonterminal illness must obtain PA for the nonhospice services (see [*Prior Authorization for Treatment of Nonterminal Conditions*](#) in *Section 5: Hospice Authorization*).

Note: Medicaid is always the payer of last resort, so nonhospice providers are reminded to first bill other payer sources before billing the IHCP.

Outpatient Physician Services for Nonterminal Conditions

If an IHCP hospice member requires outpatient physician services for conditions unrelated to the terminal condition, the member may obtain services from an IHCP-enrolled physician. The physician must obtain PA from DXC for services that are subject to PA.

The physician should then bill Medicaid directly for those independent physician services using a CMS-1500 claim form or electronic equivalent (Portal professional claim or 837P transaction).

A hospice provider's coordination responsibilities for treatment of a nonterminal condition are case-specific; however, the following guidelines should provide direction for hospice providers. If a hospice member has no physician to treat a nonterminal condition, the hospice provider should make arrangements to find a physician to treat the nonterminal condition. To ensure that the hospice member is not billed for those services, the hospice provider should make sure that the physician is enrolled as an IHCP provider.

Furthermore, the hospice provider's coordination responsibilities include advising the physician that an individual is an IHCP hospice member to ensure that any treatment for a nonterminal condition does not compromise a member's hospice care.

Inpatient Admission or Outpatient Hospital Services for Nonterminal Conditions

If an IHCP hospice member requires inpatient admission or outpatient hospital treatment for conditions unrelated to a terminal illness, the hospital should obtain PA from DXC for any services that require PA prior to billing. The hospital should then bill the IHCP directly for those services using the *UB-04* claim form or electronic equivalent (Portal institutional claim or 837I transaction).

A hospice provider's coordination responsibilities for treatment of a nonterminal condition are case-specific; however, the following guidelines should provide direction for hospice providers:

- If the hospice member currently does not receive treatment for the nonterminal condition, then the hospice provider should make arrangements to find a hospital where the hospice member may receive treatment for the nonterminal condition on an inpatient or outpatient basis, if necessary.
- To ensure that the hospice member is not billed for those hospital services, the hospice provider should make sure that the hospital-based physicians, the hospital's other medical providers, and the hospital itself are enrolled as IHCP providers.
- The hospice provider must communicate and coordinate with the nonhospice provider's personnel to ensure that any treatment for the nonterminal conditions does not compromise the member's hospice care.
- If the hospice member is admitted to a hospital from home (any residential setting other than a nursing facility), the hospice provider must submit a *Change in Status of Medicaid Hospice Patient* form to DXC that reflects the hospice member's change in residence. The same form must be completed after the hospice member is discharged from the hospital to either another institutional care setting or a private home.

Admission to a Nursing Facility for Treatment of Nonterminal Conditions

There are situations when a member receiving hospice care at home must be admitted to a hospital for treatment of a nonterminal condition and then discharged to a nursing facility for further treatment of that nonterminal condition. There are also situations when a hospice member is admitted directly into a nursing facility (without first being hospitalized) for care related to a nonterminal condition. In each of these situations, the nursing facility and hospice provider must advise the hospice member of his or her options with nursing facility care and hospice care, the services offered under each option, and the consequences of selecting either option from a patient-care, insurance-coverage, and billing perspective.

Both State and federal law require that a person applying for admission to a nursing facility must be shown to have a need for nursing facility care prior to the onset of any Medicaid reimbursement for nursing facility care. There are no exceptions to this requirement; therefore, the existing Indiana and federal PASRR requirements for nursing facility admissions apply to individuals under hospice care who are being admitted to a nursing facility. The nursing facility, hospital, and AAA must follow the current process for completing LOC and PASRR screening through the State's web-based PASRR system, as described in the [Long-Term Care](#) module. Medicaid reimbursement is not available for nursing facility care until the nursing facility has received the appropriate authorizations via the PASRR system.

IHCP payment for services provided to a hospice member in a nursing facility for conditions unrelated to the terminal illness varies depending on the following scenarios:

1. The **Medicaid-only** hospice member is discharged to a nursing facility following an inpatient hospitalization (or is admitted directly to a nursing facility, without first being hospitalized) for rehabilitation and recovery from the nonterminal condition.
2. The **dually eligible** (Medicare and Medicaid) hospice member is discharged to a nursing facility after a 3-day Medicare-qualifying hospital stay for ongoing treatment of the nonterminal condition.

Scenario 1 – Medicaid-Only Hospice Member Admitted to a Nursing Facility for Treatment of a Nonterminal Condition

If a Medicaid-only hospice member receives nursing facility care for treatment of a nonterminal condition, payment to the nursing facility must be made in compliance with the parameters outlined in *405 IAC 1-16-4*. These payment parameters apply even though the nursing facility stay is for treatment of the nonterminal condition.

This payment provision applies in the following situations:

- The hospice member resides at home and is admitted to the nursing facility for rehabilitation and recovery, either directly from home or after release from a hospital.
- The nursing facility resident is under hospice care and is admitted to the hospital for an inpatient hospital stay and then is readmitted to the nursing facility for rehabilitation and recovery after release from the hospital.

The nursing facility, nursing facility, and hospice provider have the following notification and billing responsibilities under this scenario:

- The hospice provider must submit a completed *Change in Status of Medicaid Hospice Patient* form to the DXC Prior Authorization Unit to notify the IHCP that the hospice member has been admitted to the hospital (if applicable).
- The hospice provider must continue to bill the IHCP for hospice services using revenue code 651 (routine home hospice care delivered at home) or revenue code 652 (continuous home hospice care delivered at home) while the hospice member is in the hospital, (if applicable).
- When the hospice member is admitted to the nursing facility (after being discharged from the hospital, if applicable), the hospice provider must submit a completed *Change in Status of Medicaid Hospice Patient* form to the DXC Prior Authorization Unit.
- Federal law mandates that a person applying for admission to a nursing facility must complete the PASRR process. This program is designed to identify individuals with mental illness (MI), intellectual disabilities (ID), or related conditions (RC). Proper application of this program ensures that individuals with these conditions receive the appropriate placement and services necessary to meet their needs. When a person with one or more of these conditions is approved for NF placement, the NF providers must address both the medical and behavioral needs of the resident.

- Indiana requires that residents seeking admission to an Indiana Medicaid-certified NF complete the existing LOC and PASRR screenings for nursing facility admissions through the State's web-based PASRR system as indicated.
- Hospice and nursing facility providers are reminded that the IHCP cannot reimburse hospice claims for nursing facility room-and-board services until the nursing facility has obtained the appropriate authorization via the PASRR process.
- Unlike Medicare, the IHCP does not permit a nursing facility to bill directly for treatment of the nonterminal condition. As outlined in *405 IAC 1-16-4*, the hospice provider must bill the IHCP for care provided in a nursing facility. The IHCP will pay the hospice provider 95% of the nursing facility case-mix rate and the hospice must reimburse the nursing facility per their contract. If the nursing facility fails to comply with *405 IAC 1-16-4* and bills the FSSA directly, the nursing facility will be subject to recoupment by the IHCP of any Medicaid overpayments.
- When a hospice member is discharged to home from the nursing facility, the hospice provider must submit a completed *Change in Hospice Patient Status Form* to DXC.
- When the hospice member has resumed residence in their home, the hospice provider must bill the IHCP using revenue code 651 (routine home hospice care delivered at home) or revenue code 652 (continuous home hospice care delivered at home) for those dates of service following the discharge from the nursing facility.

Scenario 2 – Dually Eligible Hospice Member Admitted to a Nursing Facility for Treatment of a Nonterminal Condition

The following issues arise when a dually eligible (Medicare and Medicaid) hospice member is admitted to the hospital with a 3-day qualifying stay and must be discharged to a nursing facility for continuation of the care provided in a hospital. The common example raised by hospice providers involve a dually eligible hospice member residing at home who falls and breaks a hip and is then admitted to the nursing facility for rehabilitation and recovery after release from a hospital.

The hospital and the hospice provider have the following notification and billing responsibilities when a dually eligible hospice member is admitted under a 3-day Medicare qualifying hospital stay:

- The hospice provider must notify both Medicare and Medicaid that the dually eligible hospice member has been hospitalized, because the hospitalization constitutes a change in hospice member status. The IHCP requires the hospice provider to submit a *Change in Status of Medicaid Hospice Patient* form to DXC. This form must also be completed when a dually eligible hospice member is discharged from the hospital and transferred to a nursing facility for treatment of the nonterminal condition.
- The hospice provider must bill Medicare Part A for hospice services for the dates of service that the hospice member is hospitalized.
- The hospital must bill Medicare for treatment of the nonterminal condition using condition code 07.

The hospice and nursing facility have the following notification and billing responsibilities when a hospice member must be transferred to a nursing facility for treatment of a nonterminal condition after a 3-day Medicare qualifying hospital stay:

- The hospice provider must notify the Medicare and Medicaid programs that this individual has been transferred from a hospital to a nursing facility. The IHCP requires the hospice provider to send a *Change in Status of Medicaid Hospice Patient* form to DXC.
- The hospice provider continues to bill Medicare Part A for the hospice services. The nursing facility is responsible for billing Medicare for treatment of the nonterminal condition using condition code 07.

- While the dually eligible hospice member is receiving treatment for the nonterminal condition, the hospice provider must **not** bill the IHCP for nursing facility room and board using revenue code 659, because Medicare is paying the nursing facility directly for treatment of the hospice member's nonterminal condition.
- After a nursing facility has completed treatment for the hospice member's nonterminal condition, the hospice member is discharged home. The hospice provider must notify the IHCP by submitting a *Change in Status of Medicaid Hospice Patient* form to DXC. The hospice provider must notify Medicare according to Medicare program guidelines.
- There may be rare occasions when a nursing facility may request durable medical equipment (DME) for a hospice member, such as a customized wheelchair. On those rare occasions, the IHCP requires the nursing facility to submit a request for prior authorization to DXC. This request for prior authorization must include a copy of Medicare's denial for this durable medical equipment.

Use of Condition Code 07 by Nonhospice Providers Billing Medicare for Nonterminal Conditions for a Medicare Hospice Beneficiary

The Medicare program specifies that nonhospice providers may bill Medicare directly by using condition code 07 when the nonhospice provider delivers Medicare-covered services to treat the nonterminal condition of a Medicare hospice beneficiary. This policy applies to dually eligible (Medicare and Medicaid) hospice members, because Medicaid is the payer of last resort.

The nonhospice provider must bill Medicare by using condition code 07. The Medicare program stipulates that nonhospice providers are subject to recovery of overpayments and possible referral for fraud and abuse investigation if a pattern of incorrect use of condition code 07 is determined.

Hospice or NF providers with questions about proper use of condition code 07 or a case-specific question involving a Medicare hospice beneficiary – whether the hospice member is Medicare-only or a dually eligible for Medicare and Medicaid – may contact the Medicare Part A Intermediary for Indiana at 1-800-633-4227. Because the IHCP is the payer of last resort, hospice providers and nursing facilities serving dually eligible hospice members must bill Medicare first for nonhospice services, according to the parameters established by Medicare.

Procedures when a Dually Eligible Member Must Remain in the Nursing Facility after the Nonterminal Condition Has Been Treated

This section addresses procedures that the hospice and nursing facility provider must follow when a dually eligible (Medicare and Medicaid) hospice member must remain in a nursing facility because the hospice member has experienced a general worsening of his or her overall condition. At this point, the hospice member's nonterminal condition has been treated and paid for by Medicare.

If nursing facility care becomes appropriate for a hospice member after a nonterminal condition has been treated, it is important that nursing facility providers ensure that the appropriate paperwork has been initiated to ensure ongoing approval for Medicaid nursing facility level of care. If the nursing facility does not have appropriate authorization via the State's web-based PASRR system, the nursing facility needs to complete the PASRR process. See the [Long-Term Care](#) module and the [PASRR](#) page at in.gov/fssa for more information.

After Medicare days for nursing facility days have been exhausted, the IHCP cannot reimburse hospice claims for nursing facility room-and-board services until the nursing facility has the appropriate authorization via the State's web-based PASRR system.

After a hospice member has been approved to reside in the nursing facility, the hospice provider may start billing the IHCP for nursing facility room-and-board services using hospice revenue code 659.

Note: Reminder to nonhospice providers: Medicaid is the payer of last resort for dually eligible (Medicare and Medicaid) hospice members.

IHCP as the Payer of Last Resort

The IHCP is always the payer of last resort, which means the hospice provider must first bill other payer sources before billing the IHCP. The following scenarios for Medicaid-only hospice members and for dually eligible (Medicare and Medicaid) hospice members provide guidelines for hospice providers.

Note: The only exception to the IHCP being the payer of last resort is if the hospice member is part of the Community and Home Options to Institutional Care for the Elderly and Disabled (CHOICE), a State-funded program administered by the Division of Aging (DA). CHOICE is funded 100% by the state of Indiana. The DA stipulates CHOICE is the funding of last resort, which means all other funding sources must be considered prior to the use of CHOICE funding.

Medicaid-Only Hospice Member Residing at Home

If a Medicaid-only hospice member residing at home (that is, in any residential setting other than a nursing facility) has private insurance, the hospice provider must first bill the private insurance for hospice services. When the private insurance company denies or partially pays the claim, the hospice provider can bill the IHCP for the remaining balance for the hospice services.

If the private insurance company has denied payment for hospice services, in whole or in part, the hospice provider must complete a *UB-04* claim form or electronic equivalent and attach a copy of the notice from the private insurance company outlining the denial of payment for those dates of service. (For claims submitted via the Portal, attachments may be uploaded electronically; for 837 transactions, attachments must be submitted separately by mail, as described in the [Claim Submission and Processing](#) module.) Upon receipt of all documentation, the IHCP processes the claim for payment.

Medicaid-Only Hospice Member Residing in a Nursing Facility

If a Medicaid-only hospice member residing in a nursing facility has private insurance, the hospice provider must bill the private insurance company first for the hospice services and the room-and-board services. When the private insurance company denies or partially pays the claim, the hospice provider can bill the IHCP for the remaining balance for the hospice services and the room-and-board services.

If the private insurance company has denied payment for hospice services or room and board, in whole or in part, the hospice provider must bill the IHCP for the outstanding balance. The hospice provider must attach to the *UB-04* claim form or electronic equivalent a copy of the notice from the private insurance company that describes denial of payment for those dates of service. (For claims submitted via the Portal, attachments may be uploaded electronically; for 837 transactions, attachments must be submitted separately by mail, as described in the [Claim Submission and Processing](#) module.) Upon receipt of all documentation, the IHCP processes the claim for payment.

If the member has private insurance, the hospice provider must bill the private insurance company first, and then bill Medicare for the outstanding balance, according to the guidelines established by Medicare.

Dually Eligible Hospice Member Residing at Home

For a dually eligible (Medicare and Medicaid) hospice member residing at home (any residential setting other than a nursing facility), the hospice provider must bill Medicare for the hospice services, and the IHCP for the outstanding balance. If the member has private insurance, the hospice provider must bill the private insurance company first and bill Medicare as the secondary payer for the outstanding balance according to the guidelines established by the Medicare program.

Dually Eligible Hospice Member Residing in a Nursing Facility

For a dually eligible (Medicare and Medicaid) hospice member residing in a nursing facility, the hospice provider must bill Medicare for the hospice services and the IHCP for the nursing facility room-and-board services.

If the dually eligible hospice member has private insurance, Medicare and the IHCP require the hospice provider bill the private insurance company first for the hospice services and the room-and-board services.

If the private insurance company denies payment, in whole or in part, for the hospice services, the hospice provider must bill Medicare for the outstanding balance according to the billing guidelines established by the Medicare program.

If the private insurance company denies payment in whole or in part for the NF room-and-board services, the hospice provider must bill the IHCP for the outstanding balance. The hospice provider must attach to the *UB-04* claim form or electronic equivalent a copy of the notice from the private insurance company that outlines denial of payment for these dates of service. (For claims submitted via the Portal, attachments may be uploaded electronically; for 837 transactions, attachments must be submitted separately by mail, as described in the [Claim Submission and Processing](#) module.)

Medicare or Medicaid Eligibility Changes during the Month

A Medicaid-only hospice member residing in an NF can become Medicare-eligible during a 1-month billing period. Inversely, a dually eligible (Medicare and Medicaid) hospice member residing in an NF can become a Medicaid-only hospice member during a 1-month billing period. The change in eligibility status changes how the hospice provider completes the claim for those dates of service.

Medicaid-Only Hospice Member in a Nursing Facility Becomes Medicare-Eligible

The following example provides guidelines for the completion of the institutional claim (*UB-04* claim form or electronic equivalent) for this scenario. The hospice provider must complete the necessary paperwork to enroll the Medicaid-only hospice member in the Medicare hospice benefit once the individual is Medicare eligible. The hospice provider must also submit the *Change in Status of Medicaid Hospice Patient* form (*State Form 48732 [4-98]/OMPP 0010*) to DXC to inform the IHCP that the member is Medicare eligible.

In this example, July 15 is the date the individual is considered dually eligible (Medicare and Medicaid) for billing purposes by both programs. The hospice provider plans to bill IHCP for the entire month of July using the following calculations:

- From July 1 to July 14, the hospice member was a Medicaid-only member so the hospice provider must bill IHCP using revenue codes 650 or 658 for those dates of service. Revenue codes 650 and 658 include the additional room and board per diem to cover costs incurred by the contracted NF.
- From July 15 to July 31, the hospice member is considered dually eligible, and the hospice provider must bill the IHCP using revenue code 659 for the additional room and board per diem for those dates of service. The hospice provider must bill Medicare for the hospice services.

Dually Eligible Hospice Member in a Nursing Facility Becomes Medicaid-Only

The following example provides guidelines for the completion of the institutional claim (*UB-04* claim form or electronic equivalent) for this scenario. The hospice provider must complete the *Change in Status of Medicaid Hospice Patient* form to inform the IHCP that the individual is no longer Medicare-eligible. The hospice provider must submit the *Change in Status of Medicaid Hospice Patient* form to the appropriate MCE or to DXC. The hospice forms are available on the [Forms](https://www.in.gov/medicaid/providers) page at [in.gov/medicaid/providers](https://www.in.gov/medicaid/providers).

For this example, July 15 is the date the member is eligible for Traditional Medicaid only. The hospice provider plans to bill the IHCP for the entire month of July.

- From July 1 through July 14, the hospice member is dually eligible for Medicare and Traditional Medicaid, so the hospice provider must bill the IHCP using revenue code 659 for the additional room and board per diem for these dates of service. The hospice provider must bill Medicare for the hospice services.
- From July 15 through July 31, the hospice member is eligible for Traditional Medicaid only, so the hospice provider must bill the IHCP for the hospice services and the additional room and board per diem for these dates of service. The hospice provider must use revenue codes 650 or 658 for those dates of service. Revenue codes 650 and 658 include the additional room and board per diem to cover costs incurred by the contracted NF.

Payment for Briefs for Hospice Patients in Nursing Facilities

Briefs are and have been included in the room-and-board portion of Medicaid hospice benefits since 1997. Hospice providers have long expressed concerns to the ISDH and FSSA that providing briefs for care related to the terminal illness or related conditions for hospice patients in a nursing facility could be construed as fraud or kickback, as briefs are considered part of the room and board per diem of Medicaid hospice benefits; however, some hospices do provide briefs for care of the terminal illness for ALL hospice patients regardless of payer source as a matter of their policy.

Representatives from CMS Baltimore on the Medicare and Medicaid Hospice Operations provided the following clarification January 2008:

If the briefs etc. are used as an inducement i.e. to obtain referrals; it would not comply with Medicare requirements and should be referred to the State OIG. IF it is a practice and part of the hospice's policy to provide briefs, etc. to ALL patients regardless of payer source or as a response to referrals, there doesn't appear to be anything that affects the Medicare hospice benefit's statute or regulations.

One additional point, my response pertained ONLY to the Medicare hospice benefit. In other words, if a patient is a resident of the nursing facility and is receiving Medicare hospice care and if the terminal or related condition requires briefs and the hospice provides briefs for ALL patients that require briefs regardless of payer source or where the care is provided, there does not appear to be a prohibition, even though briefs are not considered a covered item under Medicare. However, it would seem that briefs would be part of room and board and thus covered under Medicaid in a nursing facility or by the patient in his/her home.

If briefs are supplied by a hospice to only nursing facility patients in return for referrals, that would be prohibited.

Common Hospice Explanation of Benefits Codes

The IHCP has monitored hospice claim-denial trends since the implementation of the IHCP hospice benefit.

Explanation of benefits (EOB) codes are divided by general IHCP EOB codes and IHCP hospice EOB codes. General IHCP EOB codes are on the Remittance Advice (RA) when the IHCP claim does not meet general IHCP claims processing guidelines. The IHCP hospice EOB codes are on the RA when a hospice claim does not meet required IHCP hospice claim-processing guidelines.

Table 9 lists the most common hospice service denials, an explanation of the denial EOB codes, and how the hospice provider can avoid or correct an EOB code. These EOB codes are not an all-inclusive list, nor do they serve as a replacement for information available from Customer Assistance toll-free at 1-800-457-4584 or on [in.gov/medicaid/providers](https://www.in.gov/medicaid/providers).

Table 9 – Common Hospice Billing EOB Codes

EOB Code	Description	Explanation
236	The detail line, from date of service is missing. The correct format is MMDDYY. Please provide and resubmit.	This denial occurs when the <i>from</i> date of service is missing from a detail of the <i>UB-04</i> claim form. This denial is avoided if the provider completes the <i>from</i> date of service for all details on the claim and ensures all dates of service are legible.
385	Member's waiver liability is not met for the month.	This denial occurs when the member has not incurred enough medical expenses to satisfy the waiver liability amount for the month. This denial also occurs when the claim is submitted to DXC for processing prior to the state eligibility consultant entering the waiver liability information into the Indiana Client Eligibility System (ICES). This denial is avoided by taking the following steps: <ul style="list-style-type: none"> • Verify the recipient's eligibility status through one of the Eligibility Verification System (EVS) options. • Verify the waiver liability met date through one of the EVS options. If a waiver liability met date is not found through the EVS options, verify that the client has turned in all receipts for medical services to the county office for calculation of waiver liability met date and eligibility activation.

EOB Code	Description	Explanation
512	Your claim was filed past the filing time limit without acceptable documentation.	<p>This denial occurs when the date of service on the claim exceeds the 180-day filing limit. The supporting documentation was either not included with the claim, or it does not support efforts to bill for these services prior to the 180-day filing limit.</p> <p>This denial is avoided by submitting the claim to DXC within 180 days of the date of service. It is the responsibility of the provider to monitor the RA statements to ensure the claim was received and processed. If the claim suspends, monitor the claim until adjudication. If the claim denies, take the necessary steps to correct and resubmit.</p>
513	Member's number does not match the member's name. Please verify and resubmit.	<p>This denial occurs when the member name and IHCP Member ID (also known as RID) do not match.</p> <p>This denial is avoided by verifying that the biller has entered the correct Member ID for the member.</p>
532	Billing provider's specialty is not approved to bill this revenue code. Please verify and resubmit.	<p>This denial code occurs:</p> <ul style="list-style-type: none"> • If the provider is not approved to bill hospice services • When there is a possible duplication of services by the hospice provider and a home health provider. <p>Providers should work with a DXC provider field consultant to resolve this error. The field consultant will facilitate communication with the DXC PA Unit to resolve the EOB code.</p>
546	Type of bill incompatible for service billed.	<p>This denial occurs when incorrect revenue codes are billed with hospice claim type of bill 81x or 82x.</p> <p>To avoid this denial, providers should bill only revenue codes 183, 551, 561, 185, 650, 651, 652, 655, 656, 657, 658, and 659 with type of bill 81x or 82x.</p>
563	Hospice units billed incompatible with allowed units for the hospice revenue code.	<p>This denial occurs when the units billed are not in range for the revenue code billed.</p> <p>This denial is avoided by ensuring that the revenue code billed should have the corresponding units billed.</p> <div style="border: 1px solid black; padding: 10px; margin-top: 10px;"> <p><i>Note: The Hospice Billing Revenue Codes table in Hospice Services Codes (accessible from the Code Sets page at in.gov/medicaid/providers) provides the service units that should be listed in field 46 of the UB-04 claim form.</i></p> </div>

EOB Code	Description	Explanation
564	This revenue code is not allowed for this member's eligibility.	<p>This denial code occurs if:</p> <ul style="list-style-type: none"> • Member <i>has</i> Medicare Part A. • Type of bill is 81x or 82x. • Revenue code is 551, 561, 650, 651, 652, 655, 656, 657, or 658. <p>OR</p> <ul style="list-style-type: none"> • Member <i>does not have</i> Medicare Part A. • Revenue code is 659.
1035	Billing provider is not member's listed hospice provider. Please verify provider number and resubmit.	<p>This denial occurs when the provider is not the same provider listed in the member's file as the member's authorized hospice provider for the dates of service billed.</p> <p>This denial is be avoided by verifying that the <i>Hospice Provider Change Request Between Indiana Hospice Providers</i> form (<i>State Form 48733 [R/12-02] OMPP 0009</i>) has been completed and submitted to DXC.</p> <div style="border: 1px solid black; padding: 5px; margin-top: 10px;"> <p><i>Note: This denial has also occurred when hospice providers have used the incorrect hospice provider number from another hospice office location within Indiana or a hospice agency in another state that does not correspond to the hospice provider number listed on the hospice authorization form.</i></p> </div>
2003	Member not eligible for Indiana Health Coverage Program benefits for dates of service.	<p>This denial occurs when the member was not eligible for benefits at the time the service was provided.</p> <p>This denial is avoided by verifying eligibility prior to the provision of any services.</p> <div style="border: 1px solid black; padding: 5px; margin-top: 10px;"> <p><i>Note: It is recommended that providers check eligibility on the 1st or 15th of the month or at least monthly using one of the IHCP EVS options and document the eligibility information in the patient's file.</i></p> </div>

EOB Code	Description	Explanation
2008	Member not eligible for this level of care for dates of service.	<p>This denial occurs when the member does not have a hospice level of care on file for the dates of service billed.</p> <p>This denial is avoided by doing the following:</p> <ul style="list-style-type: none"> • Bill only after receiving approval for the certification period from DXC. • Contacting the DXC PA Unit to verify that the initial election or recertification paperwork has been received and processed by a DXC hospice analyst. Contact DXC no sooner than 14 business days after having mailed the paperwork.
2026	Member not eligible for the level of care for the dates of service and revenue codes billed.	<p>This denial occurs when a hospice recipient is billing revenue codes 650, 658, 659, 183, or 185, but a nursing facility level of care is missing or not active for the dates of service being billed.</p> <p>This denial is avoided by ensuring that the appropriate authorization has been obtained via the Preadmission Screening and Resident Review (PASRR) process.</p>
4040	The primary diagnosis code is not a valid diagnosis code. Please verify and resubmit.	<p>This denial occurs when hospice services are billed and the primary diagnosis code is not on the diagnosis table for type of bill 81x or 82x.</p> <p>This denial is avoided by checking that the primary hospice diagnosis is in field 67 of the <i>UB-04</i> claim form.</p>
4215	Leave days not a covered service for this bill type – nursing facility occupancy less than 90%	<p>This denial occurs when hospice services are billed using revenue code 180 for a dually eligible member residing in a nursing facility.</p> <p>This denial is avoided by billing claims for these members using revenue code 659.</p>
4233	Date of death/discharge is not covered.	<p>This denial occurs when a date of death/discharge occurrence code is not used. <i>CoreMMIS</i> calculates the bill twice: first for the long-term care (LTC) portion and second for the hospice portion. The code is set up to deduct patient liability and apply it to the LTC portion of the bill which is paid first, by design. Consequently, there is no balance left for patient liability. <i>CoreMMIS</i> does not apply patient liability to the routine home hospice care portion of the claim; however, third-party liability (TPL) is applied.</p> <p>If a date of death/discharge occurrence code is used for the date of death/discharge, the hospice portion of the claim is paid.</p> <p>Occurrence code 51 is used for live discharge.</p>

EOB Code	Description	Explanation
4340	Incomplete billing information for hospice SIA revenue codes 551/561. Revenue codes 551/561 require revenue codes r 651 or 650 (653 thru 12/31/2018) on same DOS, plus occurrence code 55 and member's date of death, and patient discharge status 20, 40, 41, or 42.	This denial occurs when SIA revenue codes 551 or 561 are not reported with all the following: <ul style="list-style-type: none"> • Revenue codes 651 or 650 on the same dates of service on the same claim • Occurrence code of 55 with the member's date of death in the first available occurrence code field on the <i>UB-04</i> claim form • Patient discharge status of 20, 40, 41, or 42
4341	DOS must be no more than 7 days prior to the date of death.	This denial occurs when the SIA revenue codes 551 or 561 are billed within 7 or more days from the date of death.
5001	This is a duplicate of another claim.	This denial occurs when the claim being processed is an exact duplicate of a claim on the history file or another claim being processed in the same cycle. This denial is avoided by verifying previous claim denial by using the Interactive Voice Response (IVR) system at 1-800-457-4584 or the Portal to verify previous claim payment to another provider. If a spend-down met date is not found through the EVS, verify that the client has turned in all receipts for medical services to the county office for calculation of spend-down met date and eligibility activation.

Section 7: IHCP Recoupment

The Indiana Health Coverage Programs (IHCP) recoups overpayments as they relate to the IHCP hospice benefit. The recoupment process is coordinated by the Family and Social Services Administration (FSSA) with the Claims Adjustment Unit to recoup IHCP overpayments from nursing facility providers due to noncompliance with *Indiana Administrative Code 405 IAC 1-16-4*, and from hospice providers exceeding the 20% inpatient hospice limitation detailed in the [Limitation of Payments for Inpatient Care](#) section of this document.

FSSA Recoupment from Nursing Facilities

The quarterly notification and recoupment process is as follows:

- The FSSA sends two different letters to nursing facility (NF) providers regarding the recoupment process:
 - A letter providing written notification of the names of hospice members who are identified as *hospice* on the quarterly minimum data set (MDS), but who are not enrolled in the IHCP hospice benefit. The letter should also indicate the estimated amount of the overpayment.
 - A letter that indicates an individual who is identified as *hospice* on the quarterly MDS, and who is enrolled in the IHCP hospice benefit. The letter should also identify the amount of the IHCP overpayment the NF billed the IHCP for the dates of service the NF resident was under hospice care.
- The NF is given 30 calendar days from receipt of the letter to respond to the FSSA in writing by letter or fax.
- When the response time has elapsed, the FSSA proceeds with the formal recoupment process by coordinating with the Claims Adjustment Unit.
- If there is not a recoupment issue based on the response received from the NF, the FSSA faxes a written notice to the NF provider so that the NF provider has a copy for its reimbursement records.
- If there is an IHCP recoupment from the NF, the FSSA mails a formal notice to the NF provider referencing the original letter and specifying the name and Member ID of the member who received the IHCP overpayment. The hospice provider also receives a copy of this notice.

Surveillance and Utilization Review Documentation Standards

The following sections supply documentation requirements to which hospice providers should adhere, as all IHCP providers are subject to Surveillance and Utilization Review (SUR) on-site visits, investigation by the Indiana Medicaid Fraud Control Unit, or postpayment reviews by Medicare.

Recognition of Hospice Review Process at 405 IAC 5-34-4.2

405 IAC 5-34-4.2 recognizes the hospice review process and specifies the audit of hospice services shall include review of the medical record to determine the medical necessity of services based on applicable current professional standards. The IHCP retains the right to review medical necessity and will continue to do so through the DXC hospice authorization process, Medicaid Surveillance and Utilization Review Process, and follow-up on any reported cases of program misutilization from other State agencies.

The IHCP recognizes the Local Coverage Determination (LCD) is only a guide to assist providers in determining if a patient is appropriate for hospice care and is not meant to replace the overall clinical evaluation either by the hospice provider or by the IHCP and its contractor in evaluating the unique clinical condition of each hospice member. Each hospice authorization is reviewed as a stand-alone request and should take into consideration the hospice member's unique clinical history.

Hospice providers must adhere to the LCD published by the Part A MAC for the state of Indiana when evaluating a Medicaid-only hospice member for hospice care appropriateness.

Medical Records Review

The hospice provider is required to submit specific paperwork to the DXC Prior Authorization Unit for each hospice benefit period to obtain IHCP hospice authorization for those dates of service as described in [Section 5: Hospice Authorization](#) in this module.

The IHCP hospice forms are legal documents. Hospice providers must adhere to the same medical records standards required for the completion of the hospice agency's form. Hospice providers must use these forms to document the medical necessity of the IHCP member's hospice care.

It is the hospice provider's responsibility to place the authorized hospice forms in the hospice member's medical chart at the hospice agency and at the contracted nursing facility. The inclusion of the IHCP hospice forms in the nursing facility chart is important when a member elects, revokes, or is discharged from hospice care.

The hospice provider must have the forms listed in [Table 10](#) available in the patient's medical chart to demonstrate compliance with IHCP hospice authorization, including DXC hospice authorization for that benefit period, and IHCP program compliance standards.

The IHCP hospice rule includes language specifying the forms required to be maintained by the hospice agency or the contracted nursing facility. The hospice provider is required to keep all IHCP hospice forms submitted or should have been submitted to DXC. This documentation should be kept in the hospice member's clinical chart at the hospice agency. The IHCP also expects hospice providers to include the same documentation in the hospice member's clinical chart at the nursing facility.

Although the IHCP expects these forms to be in the member's clinical chart, the review process does not include any penalty if the forms are not located in the chart during the review. The hospice provider is instructed in the summary of findings letter to correct the documentation discrepancy to ensure the hospice member's clinical records reflect accurate documentation of the member's enrollment in the IHCP hospice benefit.

Table 10 lists the documentation requirements for hospice providers to include in the patient's clinical record at the hospice agency for IHCP-enrolled only members and those having dual eligibility with Medicare.

Table 10 – Documentation Requirements for Hospice Providers

Form	Description
<i>Hospice Authorization Notice for Dually Eligible Medicare/Medicaid Nursing Facility Residents (State Form 51098 [3-03]/OMPP 0014)</i>	Dually eligible (Medicare and Medicaid) hospice members residing in nursing facilities
<i>Medicaid Hospice Election (State Form 48737 [R2/1-12])</i>	One-page hospice authorization notification with corresponding hospice agency form reflecting Medicare hospice election date. Resident is required to sign the Medicaid hospice election form to be compliant with OBRA-89.
<i>Medicaid Hospice Physician Certification (State Form 48736 [R/12-02]/OMPP 0006)</i>	Hospice agency physician certification form no longer required for IHCP postpayment review process, but still required for state hospice survey process
<i>Medicaid Hospice Plan of Care (State Form 48731 [R2/11-04]/OMPP 0011)</i>	The IHCP requires the hospice provider to meet the documentation requirements under <i>Code of Federal Regulations 42 CFR 418.112</i> to reflect a coordinated plan of care between hospice and NF agencies that demonstrates the hospice care philosophy supersedes in the care of the NF resident. The plan of care should be updated to reflect appropriate changes in the member's medical condition regarding the terminal illness and related conditions.
<i>Medicaid Hospice Revocation (State Form 48735 [4-98]/OMPP 0007)</i>	This form is used when a member revokes or chooses not to continue having hospice services.
<i>Medicaid Hospice Discharge (State Form 48734 [R/12-02]/OMPP 0008)</i>	Hospice providers complete this form when they wish to discharge a member, for example, because the member is moving out of the hospice's service area or transferring to another hospice, because the provider determines that the member is no longer terminally ill, or "for cause," as described in <i>42 CFR 418.26(a)(3)</i> .
<i>Hospice Provider Change Request Between Indiana Hospice Providers (State Form 48733 [R/12-02]/OMPP 0009)</i>	A member, or representative of the member, who is not satisfied with a hospice provider can use this form to change hospice providers during any benefit period. The hospice provider can submit this form to DXC as long as all hospice benefit periods preceding the date of the hospice revocation were previously authorized.
<i>Change in Status of Medicaid Hospice Patient (State Form 48732 [4-98]/OMPP 0010)</i>	This form is used when an IHCP member already enrolled in the IHCP hospice benefit becomes eligible for Medicare benefits midway through IHCP hospice care. The hospice member must be enrolled in the Medicare hospice benefit at the same time of Medicare eligibility. In this situation, this form must be completed and sent to the IHCP Hospice Authorization Unit. This form indicates that the IHCP member is now eligible for Medicare. For such individuals, before the initiation of hospice care, hospice providers must make adequate preparation in the event the IHCP hospice member becomes Medicare-eligible.

Hospice providers must provide the same services to a hospice member residing in a nursing facility or intermediate care facility for individuals with intellectual disabilities (ICF/IID) as it would have provided if the hospice member had been residing in his or her private home, as governed by federal regulations at 42 CFR 418.112 *Condition of Participation: Hospices That Provide Hospice Care to Residents of a SNF/NF or ICF/IID*. This section states the plan of care must describe, to the extent possible, the participation of the hospice, the facility, and the patient. The hospice and the facility must communicate with each other when any changes are included in the plan of care, and each provider must be aware of the other's responsibilities for implementing the plan of care. **Evidence of this coordinated plan of care must be present in the clinical records of both providers. All aspects of the plan of care must reflect the hospice care philosophy.** Failure to meet this medical documentation and charting criteria for a hospice patient at the nursing facility or ICF/IID is a violation of the Medicare hospice conditions of participation and State hospice licensure.

Because the IHCP is the payer of last resort, the IHCP hospice benefit has unique reimbursement issues and patient coordination issues different from the Medicare program. For this reason, the IHCP recommends hospice providers include the previously mentioned forms in a hospice member's facility chart. The inclusion of the listed forms permits the facility staff to understand a particular member is enrolled in the IHCP hospice benefit or an individual's hospice status has changed due to hospice election, revocation, or discharge. This goal cannot be accomplished if only a coordinated plan of care is included in the hospice member's facility medical record chart.

Hospice Plan of Care Review

The following criteria are used when evaluating the plan of care:

- Does the hospice plan of care show all services were delivered at the appropriate IHCP hospice level of care (LOC)?
- Is the plan of care updated to show the most recent hospice benefit period?
- Does the plan of care received by DXC match the plan of care in the member's medical records?
- Do the member's medical records indicate that all the services in the plan of care have been delivered?
- For members residing in a nursing facility, does the plan of care show coordinated care between the hospice and the nursing facility, as described in *CMS Publication 21* and *State Operations Manual, Section 2082A*?

Other Hospice Review Criteria

The following criteria are used when a hospice review is conducted at the hospice agency and includes all services billed to the IHCP by hospice and nonhospice providers for the specified review time period:

- The medical documentation of the hospice and nonhospice providers must support the services billed to the IHCP.
- The services must be IHCP benefits.
- The services must be reasonable and medically necessary to treat the terminal condition and related illnesses.
- The services must be billed in the quantities ordered and documented in the medical records as provided.
- The services must be specifically identified on the provider's itemized statements of the charge receipt maintained by the facility.
- The services must be billed to the IHCP only after other medical insurance has been exhausted.

- The services must be billed in accordance with established IHCP policy.
- The physician must order the services in writing as indicated in the medical documentation.

The following documentation is not acceptable legally or from a patient care perspective under the IHCP guidelines, and would subject the hospice and nonhospice providers to recoupment:

- Failure to document the IHCP member's name on each page of the service record is not acceptable. A patient's name is essential to ensure that the documentation is returned to the correct record, and the record pertains to the member being reviewed.
- Scratch-outs, whiteouts, alterations, missing dates, and missing signatures are not acceptable. All documentation errors should be corrected using the following universally accepted medical records method: draw a line through the entry in ink and do not obliterate the word, enter the correct information, initial, and date the change.
- Failure to include signatures to authenticate all documentation of services rendered is not acceptable. It is recommended that a full signature be used for each entry and each individual entry must be signed, including at a minimum, the first initial and last name.
 - If a first initial and last name is used, a master signature file must be maintained. The file should contain a complete (first and last name) signature and the corresponding initial and last name to be used for documentation purposes.
 - If a service requires a certain licensure level, the individual should include his or her title or credential in the signature.

Hospice providers are reminded prior authorization is not a guarantee of payment. Therefore, if the hospice review team or SUR team identifies an overpayment issue requiring recoupment, the fact the provider has prior authorization does not keep the IHCP from initiating the recoupment process.

IHCP Recommendations for Hospice Provider Coordination

Hospice providers must ensure the hospice agency is not involved with healthcare providers submitting claims for any services not reimbursable by Medicare or the IHCP based on the following program guidelines:

- Standard Medicare or IHCP benefits for treatment of the terminal illness (except as applicable for concurrent care for children)
- Treatment by another hospice not arranged for by the patient's hospice
- Care from another provider that duplicates care the hospice is required to furnish

The hospice provider must work with other nonhospice providers to coordinate care and ensure appropriate billing when these situations occur.

Recommendations for Hospice Members Residing in a Nursing Facility

The majority of IHCP hospice benefit members reside in nursing facilities. The majority of these NF residents under hospice care are dually eligible for Medicare and Medicaid. Medicare Part A pays for the hospice per diem for these members. Regardless of whether the NF resident is dually eligible or Medicaid-only, the IHCP must not be billed by nonhospice providers for any services covered under the Medicare or IHCP hospice per diem.

Pharmacy providers can bill the IHCP directly for medications for an NF resident. The IHCP has the following recommendations to minimize the occurrences of pharmacy providers and other nonhospice providers from billing the IHCP directly:

- Hospice providers and NF providers must address this coordination and notification process in their standard contracts. Specifically, the contract must do the following:
 - Identify nonhospice providers that provide services to the NF resident.
 - Establish a mechanism to notify nonhospice providers the NF resident has elected hospice.
 - Indicate services and medications included in the hospice plan of care and covered by the hospice per diem. Follow-up procedures should be identified to address those updates to the hospice plan of care for any changes to the hospice member's medications.
 - Indicate the name and address of the contact person who will send this information so the appropriate individual in the nonhospice provider's billing department is notified that the member is a dually eligible member or a Medicaid-only member.
- Hospice providers that have a contract with a particular pharmacy to provide medications for the treatment of the terminal illness should ensure that the contract specifies coordination responsibilities between the hospice and pharmacy provider. Making sure this information is specified in the contract ensures that neither Medicare nor the IHCP is inappropriately billed for medications identified in the hospice plan of care for treatment of the terminal illness. The contract must include the name and address of the contact person for each provider.
- Hospice providers should ensure the coordination efforts are documented if the nonhospice provider contacts the hospice provider for reimbursement of the IHCP overpayment.

Recommendations for Medicaid-Only Hospice Members Residing at Home

The following recommendations help ensure nonhospice providers are notified that the individual is a Medicaid-only hospice member:

- Instruct the hospice member or representative of the services covered under the IHCP hospice per diem during the admission process.
- Instruct the hospice member or representative which nonhospice providers render hospice noncore services under contract with the hospice agency. Also notify the hospice member they are required to use these services while under hospice care with that agency.
- Educate the hospice member or representative that failure to follow the hospice care philosophy or to use a provider not under contract with the hospice makes the hospice member liable for all charges resulting from the noncompliance as specified by Medicare and the IHCP.

Note: It is the hospice provider's responsibility to ensure that nonhospice providers do not bill either Medicare or the IHCP when the hospice member is noncompliant. See [Section 4: Election, Discharge, and Revocation](#) in this module for guidelines about hospice revocation versus hospice discharge.

- Provide the hospice member or representative with a list of covered medications under the hospice per diem. A new list should be provided each time the covered medications are revised per the updated hospice plan of care.
- Provide the hospice member or representative with the patient care coordinator's business card or the business card of an appropriate hospice agency staff person. This card can be used to remind nonhospice providers the member is under hospice care.

- Ensure the contract specifies coordination responsibilities between the hospice and pharmacy provider so Medicare or the IHCP is not inappropriately billed for medications in the hospice plan of care used for treatment of the terminal illness. The contract must specify the name and address of the contact person for the hospice and the pharmacy provider so the pharmacy provider can contact the hospice provider about which medications the pharmacy provider must bill.
- Hospice providers that contract any part of the hospice noncore services for treatment of the terminal illness must ensure the contractor bills the hospice provider directly for those services. Medicare or the IHCP must not be billed directly by these nonhospice providers as these services are covered under the hospice per diem and are under the supervision of the hospice provider.
- As part of the admission process and subsequent hospice visits, the patient or the patient's representative must be asked whether any new provider or staff person is coming to see the patient since the last visit. This information allows the hospice provider to follow up and develop a coordinated plan of care with that entity.

Section 8: Hospice Care in Nursing Facilities

This section provides an overview of hospice care provided in nursing facilities. This section provides information regarding:

- Hospice conditions of participation
- Level-of-care (LOC) requirements for billing room and board under the Indiana Health Coverage Programs (IHCP) hospice benefit
- B98 autoclosures
- An explanation of payment, and billing parameters for hospice and nursing facilities based on a member's election, discharge, and revocation of hospice services
- Discussion of hospice care and nursing facility room-and-board services based on the Centers for Medicare & Medicaid Services (CMS) clarification regarding nutritional supplements

Hospice Conditions of Participation

The hospice conditions of participation codify the care standards in nursing facilities by incorporating *Code of Federal Regulations 42 CFR 418.112: Condition of Participation: Hospices That Provide Hospice Care to Residents of a SNF/NF or ICF/IID*. The care expectations are consistent with the information in this module.

State law requires the IHCP hospice program to mirror the coverage and reimbursement methodology of the Medicare hospice program.

The hospice provider is required to adhere to certain contractual responsibilities when entering a contract with a nonhospice provider for a service related to the member's terminal illness or related conditions. The contract requires the nonhospice provider to bill the hospice for those services at the fair market value rate noted in the contract. The nonhospice provider must not bill the IHCP for those services separately, because it would be considered duplicate billing and subject the nonhospice provider to recoupment.

It is important that the hospice consult with an attorney for all contractual issues and to ensure that the contracts are compliant with the safe harbor laws. Hospice providers can address the following issues in their contracts:

- Specification of what is included in room-and-board services and whether the hospice pays 95% or 100% of the nursing facility daily rate
- Specification of additional hospice noncore services and the rates the hospice will pay for each
- Specification whether the hospice is the manager of the resident's hospice care and as such the nursing facility must seek authorization from the hospice provider for any change to the agreed-upon plan of care
- Procedures for hospice to provide regular in-service training to the nursing facility staff regarding the hospice care philosophy
- Notification sections specifying the name of the contact person for each entity
- Specification indicating room and board under the Medicaid hospice benefit cannot be made for dates of service the resident was ineligible for the Medicaid hospice benefit, did not have Medicaid nursing facility level of care, or the nursing facility was decertified from the Medicaid program
- Notification procedures for the nursing facility to inform the hospice when an approved authorization is issued via the Preadmission Screening and Resident Review (PASRR) process.

- Notification procedures a nursing facility must follow to inform the hospice about Medicaid decertification as a result of State Department of Health survey, which may also include hospice participation in the discharge/transfer of a resident to another Medicaid-certified facility
- Attendance of appropriate hospice staff at nursing facility interdisciplinary team meetings and attendance of appropriate nursing facility staff at hospice interdisciplinary meetings
- Billing and payment parameters between hospice and nursing facility
- Specification of the respective care responsibilities of hospice and nursing facility staff based on a detailed description of the hospice level of care and the nursing facility room-and-board services under the Medicaid hospice benefit
- Procedures that must be followed by hospice and nursing facility staff when a resident under hospice care requires hospitalization for either the terminal illness or the nonterminal illness; for example, nursing facility must contact hospice for authorization, determination of which hospital the resident will be admitted, the billing and payment parameters, and so forth
- Procedures for the disposal of medications after the hospice member dies

Requirements for Billing Hospice Services Provided in a Nursing Facility

A member must have received prior authorization for hospice services and also must have been determined to meet nursing facility level of care (LOC) for the dates the hospice is requesting reimbursement for nursing facility room-and-board services under the IHCP hospice benefit.

*Note: When verifying eligibility on the IHCP Provider Healthcare Portal, providers must confirm that both “Hospice Program” and “Nursing Facility Level of Care” are listed in the **Institutional Level of Care and Hospice** panel for the member on the date of service.*

The Family and Social Services Administration (FSSA) Division of Aging has noted the following issues with regard to nursing facility LOC for hospice members:

- Nursing facility staff submits a new LOC screen (via the State’s web-based PASRR system) for IHCP nursing facility level of care when a nursing facility resident revokes hospice or the resident is discharged from hospice care. If the resident has a current IHCP nursing facility LOC for Medicaid reimbursement, the nursing facility does not need to resubmit a new LOC screen for nursing facility level of care.
- The hospice is required by federal law to notify the State Medicaid agency when a member elects, revokes, is discharged, or changes providers under the Medicare and Medicaid programs. The hospice must submit a Medicaid revocation form or Medicaid hospice discharge form to the IHCP prior authorization contractor so that the hospice level of care can be updated with these changes. If a hospice fails to submit the Medicaid hospice revocation form or the Medicaid hospice discharge form, then nursing facility claims will deny for service dates following the hospice revocation or discharge because the member will still be identified as a hospice member in the IHCP eligibility system.

Room and board under the IHCP hospice benefit is outlined at *Indiana Administrative Code 405 IAC 1-16-4*:

- Performing personal care activities (not otherwise performed by the hospice provider)
- Assisting with activities of daily living (ADL)
- Administering medication

- Socializing activities
- Maintaining the cleanliness of a patient's room
- Supervising and assisting in the use of durable medical equipment and prescribed therapies
- While not explicitly listed at *405 IAC 1-16-4*, the nursing facility should continue to provide all dietary and laundry services for care of the nursing facility resident who elected hospice.

Skilled nursing facility or nursing facility (SNF/NF) services offered to a patient or resident should be the same whether or not he or she has elected hospice. This means that if the member has a diagnosis or condition that is **unrelated** to the terminal illness, the nursing facility must still provide that service.

It is the responsibility of the hospice as the manager for the patient's end-of-life care to indicate in the coordinated plan of care that the service is unrelated to the terminal illness. If the documentation does not support this distinction between terminal and nonterminal illness, the hospice is subject to recoupment by Medicare or Medicaid.

B98 Autoclosures

When a hospice provider receives a claim denial for explanation of benefits (EOB) code 2026 – *Member not eligible for the level of care for the dates of service and revenue codes billed*, it can possibly be related to a B98 autoclosure as a direct result of prior nursing facility provider billing or the hospice provider inappropriately billing patient status.

In those circumstances, it is the responsibility of the nursing facility to provide the necessary documentation to the Long Term Care Help Desk. The help desk may be reached at (317) 488-5094. The hospice will continue to receive a denial for EOB 2026 until the B98 autoclosure.

Payment and Billing Parameters for Hospice and Nursing Facilities

The following table illustrates when nursing facility billing stops and when nursing facility billing resumes for nursing facility care based a member's IHCP hospice benefit status.

Table 11 – Hospice and Nursing Facilities Payment and Billing Parameters

Hospice Enrollment Status	Hospice Billing	Nursing Facility Billing
Hospice Election	Hospice bills for room and board starting the date of hospice election	Nursing facility must stop billing Medicaid the date of hospice election
Hospice Revocation	Hospice bills Medicaid for room and board the date of hospice revocation	Nursing facility resumes direct Medicaid billing the day after the hospice revocation
Hospice Discharge	Hospice bills Medicaid for room and board the date of hospice discharge	Nursing facility resumes direct Medicaid billing the day after the hospice discharge
Nursing facility date of death or date of resident's physical discharge from facility	Hospice must not bill date of death or date of resident's physical discharge	Nursing facility regulations do not permit payment for date of death or date of resident's physical discharge from facility

Note from the CMS to the FSSA: Amounts paid to the nursing facility above 100% of the Medicaid daily rate should be limited to nonroutine equipment, supplies, and therapies that are related to the patient's terminal illness and paid to the nursing facility or an affiliated supplier at cost or obtained from an independent supplier.

CMS Clarification Regarding Nutritional Supplements

According to the CMS, nutritional supplements that are necessary as a result of the terminal illness are the financial responsibility of the hospice. Provision of such supplements is viewed as above and beyond the dietary services a nursing facility traditionally provides. Even though some nursing facilities would be required to provide nutritional supplements for nonhospice participants, the election of hospice transfers the payment obligation to hospice for those services related to the terminal illness.